



**SOCIAL ENTREPRENEURSHIP IN KENYA: UNDERSTANDING
MODELS, DRIVERS, CONSTRAINTS AND OPPORTUNITIES FOR
ENHANCED IMPACT IN HEALTHCARE**

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ABSTRACT

Social entrepreneurship is a rising field, gaining momentum and recognition. With the impact it is already having plus its substantial scope for further growth and influence, it is important to understand the dynamics that drive and affect it as well as the ecosystem it sits within. At present, there is very limited research available on social entrepreneurship in a developing country setting and even less on its application within the health sector. Hence, the purpose of this study is to understand the objectives, operations, and challenges of social enterprises in Kenya, with a specific focus on the health sector. As an exploratory study, an open, grounded theory, qualitative approach was adopted to allow the generation of insight into this little understood context. This research presents a set of emerging themes and propositions that answers the primary research question: *What drives and affects innovation among social enterprises in Kenya's health sector?* Ultimately it provides a theoretical framework that addresses the core concern of establishing a social enterprise that has impact in a developing country's health sector. The themes that emerged from the data throughout the study support the following main conclusions: 1) The character, perspective and experience of the social entrepreneur(s) in combination with the identified needs (opportunities) drive innovation in Kenya's health sector and 2) Challenges, enablers and environmental influencers (infrastructure, regulatory/ political, support and operational) affect the operation and innovation of social enterprises in Kenya's health sector.

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GLOSSARY OF TERMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
BoP	Bottom of the Pyramid
CEO	Chief Executive Officer
CDC	Centre for Disease Control
CSO	Civil Society Organisation
CDF	Community Development Fund
DFID	Department for International Development
DP	Development Partner
EASEN	East Africa Social Enterprise Network
FBO	Faith Based Organisation
GDP	Gross Domestic Product
GF	Global Fund
GoK	Government of Kenya
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HP	Health Provider
HW	Health Worker
ICT	Information and Communications Technology
JPWF	Joint Programme of Work and Funding
KEBS	Kenya Bureau of Standards
KEPH	Kenya Essential Package for Health
KEMSA	Kenya Medical Supplies Agency
KEPSA	Kenya Private Sector Alliance
KHP	Kenya Health Policy
KHS	Kenya Health Sector
KHPFP	Kenya Health Policy Framework Paper
KSH	Kenya Shilling
MDGs	Millennium Development Goals
MD	Medical Doctor
MoH	Ministry of Health
MoMS	Ministry of Medical Services
MoPHS	Ministry of Public Health and Sanitation
MSMEs	Micro, Small and Medium Enterprises
NAFD	National Average Facility Density
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NHIF	National Health Insurance Fund

NRTH	National Referral and Teaching Hospitals
NHSSP	National Health Sector Strategic Plan
NSA	National Strategic Approach
ODI	Overseas Development Institute
PEPFAR	Presidential Emergency Programme for AIDS Response
PHC	Parliamentary Health Committee
PRSP	Poverty Reduction Strategy Paper
PSDS	Private Sector Development Strategy
SARAM	Service Delivery and Readiness Mapping
SBP	Single Business Permit
SEs	Social Enterprises
STDs	Sexually Transmitted Diseases
SWAp	Sector Wide Approach
TB	Tuberculosis
THE	Total Healthcare Expenditure
TI	Transparency International
UNCTAD	United Nations Conference of Trade and Development
USAID	United States Agency for International Development
WHO	World Health Organisation

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At the time of submission, two publications have so far come out of this collaborative project:

Griffin-EL, E., Darko, E., Chater, R. and Mburu, S. (2014). **A case study of health and agriculture social enterprises in Kenya.** *Overseas Development Institute Report*, March 2014. [Online] Available at: <http://www.odi.org/publications/8305-case-study-health-agriculture-social-enterprises-kenya>

Darko, E. and Smith, W. (2014). **Social Enterprise: constraints and opportunities – evidence from Vietnam and Kenya.** *Overseas Development Institute Report*, March 2014. [Online] Available at: <http://www.odi.org/publications/8303-social-enterprise-constraints-opportunities-evidence-vietnam-kenya>

While there is some overlap in subject and content, the research done for this thesis is specific and original.

1. INTRODUCTION

1.1 Research Area

Social entrepreneurship refers to the process of creating market-oriented solutions that address social and environmental problems (Martin & Osberg, 2007). Such solutions are created with the larger ambition of changing patterns and shifting institutions towards advancing social change that better supports human and natural life (Dacin, Dacin, & Matear, 2010). As a field of practice, social entrepreneurship is fostering the emergence of cutting-edge business models, networks, and innovations that are providing unique goods and services to the marginalized and making society more inclusive and fair. As a field of knowledge and research, social entrepreneurship is pushing the boundaries of the role of business and entrepreneurial thinking within the social change discourse. It is also posing new questions as to how the conceptual intersection of social priorities and economic sustainability can make way for doing business more relevantly.

Business communities, social development campaigns, and academic institutions throughout Africa and around the world are starting to recognise the potential of social enterprises. This is leading to an emergence of support organizations and relevant policy geared towards building conducive environments for social enterprises to operate within. In this way, social enterprises are better enabled to meet their objectives, carry out their operations, exploit new opportunities, and address looming challenges. The African continent is increasingly hosting and advocating for social innovation that reshapes the way society functions and encourages entrepreneurial activity to drive this innovative process. Although the recognition and development of social entrepreneurship is gaining momentum, it is still a long way off from being established in societal norms and structures.

Understanding the ecosystem within which this process of recognition, development and establishment sits is an important area of study. It provides insight into the barriers, challenges, opportunities, communities, policies and support networks facing social enterprises. This in turn allows practical recommendations to be offered of how to improve the field for enhanced impact.

Kenya, as a hub of technology and business innovation in its region, provides a unique combination of both great need and great opportunity. It stands as an ideal location for a case study. Healthcare, as a key right and central aspect of social wellbeing, is a relevant sector to focus on. Hence, the purpose of this study is to understand the objectives, operations, and challenges of social enterprises in Kenya, with a specific focus on the health sector.

1.2 Problem Definition and Research Questions

In acknowledging social entrepreneurship as an increasingly thriving approach in Kenya, the problem lies in how the challenges facing social enterprises can be minimised, the existing structures of support enhanced and innovation encouraged. The identification of barriers and opportunities in the surrounding ecosystem is therefore central. This research assumes that although social enterprises are making significant progress in enriching the lives of the poor and excluded, there is still more that can be done to enhance a coherent and enabling environment for them. Furthermore, the study assumes that challenges which social enterprises now face can be converted into possibilities for innovation and new arrangements of structures and institutions.

The principal research question is therefore: ***What drives and affects innovation among social enterprises in Kenya's health sector?*** Where innovation is defined as the development of processes, programmes or products that can enable improved care delivery in an inclusive, effective and affordable way whilst simultaneously encouraging change in the routines, resources and values within the health system.

This raises a number of further research questions:

- Who are the key actors and how do they shape the environment for social entrepreneurship within the health sector in Kenya?
- What are the key challenges and barriers to innovation through social entrepreneurship in the health sector in Kenya and how have social enterprises dealt with these?
- What are the key needs and opportunities that spur innovation within the health sector in Kenya and what are the models that have been created to meet these needs and exploit these opportunities?

Ultimately, by having a direct sectoral focus, the research will be able to examine the details of social enterprises' contribution to the sector. It also allows the means by which engagement with multiple actors in these sectors condition their work to be shown. Ideally, in exploring how social enterprises and the surrounding actors engage – or fail to engage – with one another, the study will highlight the challenges and opportunities of inclusively harmonizing their efforts.

1.3 Research Objectives

The principal objective of this study is to explore the context and generate a theory that addresses the research questions presented above. This is approached using a grounded theory methodology. As such, it was important to set aside any preconceptions or assumptions and undertake the research with an open mind, being responsive to the themes that emerge. Finally, a set of propositions are produced and form the core findings of the study. All these propositions form the building blocks of hypotheses that could be tested individually in further detailed research projects. However, as an explorative study collecting primary qualitative data to analyse, the focus of this research is not geared towards testing an already formulated hypothesis but rather structured around creating a theoretical framework from a previously little-understood context.

Ultimately, the study intends to be able to offer findings/recommendation to actors on the three levels of the ecosystem explored. Those three levels are:

- ***Policy and regulation.*** To inform the direction of policy in incentivizing and permitting activity, partnerships, and uses of resources that encourage and support social entrepreneurship.
- ***Support and service infrastructure.*** To assess information drawn from social entrepreneurs' experiences and perspectives that will aid in strengthening support organizations' offerings, so that their help is more pertinent.
- ***Individual enterprise and operational structures.*** To offer insight as to how social enterprises can better leverage opportunities and relationships to make their operations more efficient and effective.

2. LITERATURE REVIEW

2. Overview

In a grounded theory study, the place of the literature review is greatly debated (Dunne, 2011). Glaser and Strauss (1967) place emphasis on the discovery of emergent theory and therefore (in contrast to most research approaches) discourage researchers from engaging with the existing literature until completing their own analysis so as not to contaminate the findings. Strauss and Corbin (1990) deviate from this and suggest doing a literature review before the analysis begins. Although they acknowledge the dangers of becoming prejudiced, primed or ‘awed-out’ by the work of others, they see the literature review as an important vehicle for facilitating theoretical sampling. For this research, the context and background of social entrepreneurship, the Kenyan eco-system, the Kenyan health sector and social entrepreneurship in health will be reviewed in this chapter. This allows an understanding of the environment to frame the analysis without pre-empting particular findings. Empirical and conceptual work from other studies that relate to the emerging themes from this research will be presented alongside the theoretical framework developed in Chapter 4 (Research Findings, Analysis and Discussion).

2.1 Social Entrepreneurship – A Rising Phenomenon

We are in an age where researchers and practitioners claim that the boundaries between the government, non-profit and business sectors of the economy are blurring (Ryan, 1999; Glover, 2012). As such, the search for more innovative, sustainable and cost-effective ways to address social problems and deliver socially important goods, such as basic education and health care, becomes more widespread and prominent. This search has resulted in experimentation with the use of business models and strategies to achieve social outcomes and improve the performance of traditionally non-business sectors (Glover, 2012). Bornstein and Davis (2010: xix) propose that “the emergence of the citizen sector and social entrepreneurship is an adaption to the changing demands of the global environment, a departure from the top-down, centralised problem solving model that dominated the past century”. But it is important to note that the discussion around social entrepreneurship as an “emerging field” has to do with the emergence of a new and specific way of framing and talking about a field that has otherwise been around, in varying forms, for a long time (CASE, 2008).

Social entrepreneurship is gaining momentum as a tool for affecting positive change in many different arenas across society. Characterised variably as a profession, field or movement, social entrepreneurship is not a new phenomenon but in its current form is growing in prominence and popularity (Bornstein & Davis, 2010: 1). Its definition, however, remains disputed. It is therefore helpful to look at different interpretations of the concept and clarify how it is distinct from other similar ideas by examining its scope in theory and practice. This section will present an overview of the theory of social entrepreneurship including a look at its definition, evolution, potential and limitations as well as identifying some key issues and its use for the purpose of this paper.

2.1.1 Defining Social Entrepreneurship

There is no universally accepted definition of social entrepreneurship (Dees, 1998). Many definitions emphasise different dimensions of social entrepreneurship, ranging from the personalities and approaches of social entrepreneurs to the unique characteristics and priorities of social enterprises (SEs) have been offered. Perhaps a helpful starting point for understanding social entrepreneurship is to look at the root concept of entrepreneurship in its traditional sense and then see how it is modified to focus on ‘the social’.

The term entrepreneur originated in French economics in the 17th and 18th centuries and was used to refer to someone who undertook a significant project and “stimulated economic progress by finding new and better ways of doing things” (Dees, 1998). Jean Baptiste Say described the entrepreneur as one who creates value by “shifting economic resources out of an area of lower and into an area of higher productivity and greater yield” (Baptiste Say as quoted in Dees, 1998: 1). Another major thinker in the field, Joseph Schumpeter, proposed that entrepreneurs are the change agents in the economy who, by serving new markets or creating new ways of doing things, move the economy forward (Dees, 1998). In short, entrepreneurship is innovative and change-orientated. It involves the identification, evaluation and exploitation of opportunities, usually for private gain (Certo & Miller, 2008). As entrepreneurship essentially describes a mind-set or approach that can manifest anywhere, social entrepreneurship is the specific application of this approach to address social issues in innovative, effective and sustainable ways. For the social entrepreneur, “mission related impact becomes the central criterion, not private wealth creation” (Dees, 1998: 2). Wealth becomes a means to an end rather than a way of measuring value creation itself.

Table 1 brings together definitions from some of the key academics and practitioners in social entrepreneurship literature. The table is divided into three categories: 1) social entrepreneurship; 2) social entrepreneurs; and 3) social enterprises. Definitions of social entrepreneurship typically refer to an approach, process or behaviour. Definitions of social entrepreneurs focus instead on the founder of the initiative. Finally, definitions of social enterprises refer to the tangible outcome of social entrepreneurship (Mair & Marti, 2004: 3). As shown below, most definitions focus on four key factors or some combination of them: 1) the characteristics of the individual social entrepreneur; 2) the sector in which they operate; 3) the processes and resources they use; and 4) the primary mission and outcomes associated with the enterprise (Dacin, Dacin & Matear, 2010).

Table 1. Definitions of Social Entrepreneurship, Social Entrepreneurs and Social Enterprises

<u>SOCIAL ENTREPRENEURSHIP</u>	
Mort, Weerawardena, & Carnegie (2002)	Social entrepreneurship is a multidimensional construct involving the expression of entrepreneurially virtuous behavior to achieve the social mission, a coherent unity of purpose and action in the face of moral complexity, the ability to recognize social value- creating opportunities and key decision-making characteristics of innovativeness, proactiveness and risk-taking.
Lasprogata & Cotten (2003)	Social entrepreneurship means nonprofit organizations that apply entrepreneurial strategies to sustain themselves financially while having a greater impact on their social mission (i.e., the “double bottom line”).
Alvord, Brown, & Letts (2004)	Social entrepreneurship creates innovative solutions to immediate social problems and mobilizes the ideas, capacities, resources, and social arrangements required for sustainable social transformations.
Mair & Marti (2004)	Social Entrepreneurship is a process that catalyzes social change and/or addresses important social needs in a way that is not dominated by direct financial benefits for the entrepreneurs. Social entrepreneurship is seen as differing from other forms of entrepreneurship in the relatively higher priority given to promoting social value and development versus capturing economic value.
Hibbert, Hogg, & Quinn (2005)	Social entrepreneurship can be loosely defined as the use of entrepreneurial behaviour for social ends rather than for profit objectives, or alternatively, that the profits generated are used for the benefit of a specific disadvantaged group.
Saïd Business School (2005)	Social entrepreneurship may be defined as a professional, innovative, and sustainable approach to systemic change that resolves social market failures and grasps opportunities.
Paredo & Mclean (2006)	Social entrepreneurship is exercised where some person or persons (1) aim either exclusively or in some prominent way to create social value of some kind, and pursue that goal through some combination of (2) recognizing and exploiting opportunities to create this value, (3) employing innovation, (4) tolerating risk and (5) declining to accept limitations in available resources.
Austin, Stevenson, & Wei-Skillern (2006)	Social entrepreneurship involves the recognition, evaluation, and exploitation of opportunities that result in social value — the basic and long-standing needs of society — as opposed to personal or shareholder wealth. It is an innovative, social value creating activity that can occur within or across the non-profit, business, or government sectors.
Zahra, Gedajlovic, Neubaum & Shulman (2009)	Social entrepreneurship encompasses the activities and processes undertaken to discover, define, and exploit opportunities in order to enhance social wealth by creating new ventures or managing existing organizations in an innovative manner.
Bornstein & Davis (2010)	Social entrepreneurship is a process by which citizens build or transform institutions to advance solutions to social problems, such as poverty, illness, illiteracy, environmental destruction, human rights abuses and corruption, in order to make life better for many.
Granados, Hlupic, Coakes & Mohamed (2011)	<i>Social entrepreneurship</i> is the activity developed by individuals or groups of people to create, sustain, distribute and/or disseminate social or environmental value in innovative ways through enterprise operations, which could be either a social enterprise, non-profit, private or public institution.

SOCIAL ENTREPRENEURS

Boschee (1998)	Social entrepreneurs are not-for-profit executives who pay increasing attention to market forces without losing sight of their underlying missions, to somehow balance moral imperatives and the profit motives – and that balancing act is the heart and soul of the movement.
Dees (1998)	Social entrepreneurs play the role of change agents in the social sector, by: 1) Adopting a mission to create and sustain social value (not just private value), 2) Recognizing and relentlessly pursuing new opportunities to serve that mission, 3) Engaging in a process of continuous innovation, adaptation, and learning, 4) Acting boldly without being limited by resources currently in hand, and 5) Exhibiting a heightened sense of accountability to the constituencies served and for the outcomes created.
Thompson, Alvy & Lees (2000)	Social entrepreneurs are people who realize where there is an opportunity to satisfy some unmet need that the state welfare system will not or cannot meet, and who gather together the necessary resources (generally people, often volunteers, money and premises) and use these “to make a difference”.
Boschee & McClurg (2003)	A social entrepreneur is any person, in any sector, who uses earned income strategies to pursue a social objective, and a social entrepreneur differs from a traditional entrepreneur in two important ways: Traditional entrepreneurs frequently act in a socially responsible manner.... Secondly, traditional entrepreneurs are ultimately measured by financial results.
Light (2006)	A social entrepreneur is an individual, group, network, organization, or alliance of organizations that seeks sustainable, large-scale change through pattern-breaking ideas in what or how governments, nonprofits, and businesses do to address significant social problems.
Zahra, Gedajlovic, Neubaum & Shulman (2009)	Social entrepreneurs make significant and diverse contributions to their communities and societies, adopting business models to offer creative solutions to complex and persistent social problems.

SOCIAL ENTERPRISE

Dees (1994)	Social enterprises are private organizations dedicated to solving social problems, serving the disadvantaged, and providing socially important goods that were not, in their judgment, adequately provided by public agencies or private markets. These organizations have pursued goals that could not be measured simply by profit generation, market penetration, or voter support.
Haugh & Tracey (2004)	Social enterprises are businesses that trade for a social purpose. They combine innovation, entrepreneurship and social purpose and seek to be financially sustainable by generating revenue from trading. Their social mission prioritises social benefit above financial profit, and if and when surplus is made, this is used to further the social aims of the beneficiary group or community and not distributed to those with a controlling interest in the enterprise.
Hockerts (2006)	Social purpose business ventures are hybrid enterprises straddling the boundary between the for-profit business world and social mission-driven public and nonprofit organizations. Thus they do not fit completely in either sphere.
Maretich & Bolton (2010)	An organisation that focuses on achieving social impact, applying market-based solutions to address public sector and market failures in innovative ways.
Granados, Hlupic, Coakes & Mohamed (2011)	Social enterprise is an organizational form with primarily social drivers that undertakes innovative business operations in order to be auto-sustainable and guarantees the creation, sustainment, distribution and/or dissemination of social or environmental value. Therefore, economic drivers are means to a social end, not the end in itself

(Source: updated from Mair & Marti, 2004)

Some definitions give social and economic objectives equal weighting in what is referred to as the ‘double bottom line’ or ‘doing well whilst doing good’. Others more strongly emphasize the clear motive of achieving socially desirable objectives. These imply that social entrepreneurship exists to exploit opportunities for social change and improvement, rather than traditional profit maximisation (Zahra, Gedajlovic, Neubaum & Shulman, 2009: 521). Firms who exist primarily to pursue profits as well as those not-for-profit, non-government or social service organisations that ignore the economic sustainability of their operations, would generally fall outside the scope of social entrepreneurship (Zahra et al, 2009). Social entrepreneurs tend to focus on all three of the following central elements: social impact, change and sustainability, thereby distinguishing them from other similar entities.

Social entrepreneurship is distinct from business entrepreneurship, governance or activism in a number of ways. As noted earlier, the main difference between social and traditional business entrepreneurship has to do with purpose or overall mission (i.e. maximise social impact rather than profits). Emerson and Twersky (1996) note that while business entrepreneurs may create social value in the process of pursuing private gains and social entrepreneurs may indeed produce private gains in the process of pursuing social value, the driving mission of the two sets them apart.

Directly related to their missions is the performance measure of each type. Business entrepreneurship focuses on financial performance metrics such as profitability or sales growth, which are easy to understand and measure. Social entrepreneurs are left with the difficult task of measuring social value. This leads to another difference in how resources are mobilised. Business entrepreneurs can attract financial resources by offering the potential of financial returns for investors. Human resources are similarly attracted by the potential returns of the enterprise. Certo and Miller (2008) argue that without these clear financial rewards, social entrepreneurs may face difficulties obtaining financial resources. This challenge is slowly being addressed through the rise of philanthropic venture capital funds such as Ashoka, Echoing Green and the Acumen Fund which provide resources and advice for new social ventures. In the absence of being able to pay market rates for high talent employees however, finding individuals with similar motives as the social entrepreneur is key to addressing human resource constraints (Certo & Miller, 2008).

Social entrepreneurship is also distinct from government ventures to address social and environmental issues. Its approach is often more bottom up with an appreciation for ground level details and greater flexibility in response than that employed by governments. Resources are often significantly more limited however and there has to be buy-in for success in the absence of the ability to command compliance (Bornstein & Davis, 2010). While many social entrepreneurs incorporate activism into their ventures, it is distinct from activism. Where activists “seek change by influencing the decision making of large institutions or by changing public attitudes, social entrepreneurs pursue a wider range of options, including building institutions that directly implement solutions themselves” (Bornstein & Davis, 2010: 38).

Zara et al (2009: 519) identify three types of social entrepreneurs: Social Bricoleur, Social Constructionist, and Social Engineer. Social Bricoleurs typically focus on discovering and addressing small-scale local social needs. Social Constructionists usually “exploit opportunities and market failures by filling gaps to underserved clients in order to introduce

reforms and innovations to the broader social system” (ibid). In contrast, Social Engineers “recognize systemic problems within existing social structures and address them by introducing revolutionary change” (ibid). The latter tends to lead to the destruction of outdated systems and the introduction of newer, more suitable ones.

Social enterprises are the usual output of social entrepreneurial activity. Social enterprise models come in a number of forms of which perhaps the three broadest categories of organisational structures are: 1) leveraged non-profits, where the entrepreneur sets up a non-profit organisation (NPO) to drive the innovation. Although it may require external funding, it has the commitment of cross-sector actors thus enhancing sustainability; 2) hybrid non-profits, where the entrepreneur sets up an NPO but includes some degree of cost-recovery through the sale of goods and services to a cross section of partnering institutions; and 3) hybrid for-profits or social businesses where a business is set up to drive societal change or improvement with wealth generation subordinate to social goals (Hartigan, 2006).

Maretich and Bolton (2010: 7) in their report for European Venture Philanthropy Association further break down the sub-types of social enterprises into the following six categories: Those that 1) Are led by a social entrepreneur, applying entrepreneurial solutions to solve social problems; 2) Grow up within or alongside charities, usually with the purpose of supporting the charity through trading activities; 3) Trade extensively with the public sector; 4) Are private sector businesses with a social purpose; 5) Form part of a broader, integrated programme for social benefit; and 6) Share a legal form recognized in individual countries as social enterprise.

For the purposes of this study, a social enterprise (undertaken by a social entrepreneur) *is a business operation which has social or environmental objectives which significantly modify its commercial orientation*. A ‘business operation’ here is defined as a non-state entity which derives a significant proportion of its revenue from selling goods or services. Forms of modification of commercial orientation typically fall into a number of categories. Business operations may exhibit one or more of the following, or other, types of modification: 1) Sharing of financial surpluses with customers by including them as co-owners of the enterprise to achieve a social objective (co-operatives); 2) Purposefully reducing financial surpluses by paying above-market premiums or guaranteed prices to suppliers (fair trade), above market wage rates to employees or restraining business margins within fixed limits (e.g. Grameen Bank) in order to achieve a social objective; 3) Purposefully cross-subsidising a specific category of customer as part of core business practice in order to achieve a social objective; and

4) Seeking a long term partial subsidy from a government, donor or non-government organisation (NGO) source in order to sustain a business which would not otherwise be viable in order to achieve a social objective. The subsidy may be provided in the form of direct financial subsidy or privileged or protected access to markets (e.g. government procurement contracts).

2.1.2 Some Key Issues

As can be appreciated by the range of definitions proposed above, agreeing on the content and boundaries of the concept of social entrepreneurship is a source of much debate. While some scholars welcome the openness of the concept, others argue that it will serve to weaken its potential for growth and impact. Martin and Osberg (2007: 30) push for greater clarity. They argue that if “too many ‘non-entrepreneurial’ efforts are included in the definition, then social entrepreneurship will fall into disrepute, and the kernel of true social entrepreneurship will be lost” (ibid).

Another big issue is how to measure social impact or value. Markets function well for business enterprises but tend to do a poor job of evaluating social improvements, which is central to the social enterprise (Dees, 1998). Social value is very subjective and many of the outcomes of social ventures are intangible or hard to quantify. Standardised measurements for evaluation can therefore be difficult to obtain or construct. For instance, measuring the social value of pollution reduction, empowerment of women in oppressive societies, protection of human rights or access to clean water and health services in remote rural areas is intrinsically difficult to quantify or compare. As a result, it is much harder to determine whether a social entrepreneur is creating sufficient social value to justify the resources used in creating that value.

Zahra et al (2009) propose a metric to help determine whether the economic and social value created offset the economic and social costs incurred. It involves measuring the ‘total wealth’ created, which includes tangible (e.g., products, clients served, or funds generated) and intangible outcomes such as wealth, happiness and general well-being (Zahra et al, 2009: 522). Even with their carefully constructed metric, difficulties remain for measuring the intangibles. The lack of definitional consensus, the variety of organisational forms in addition to the difficulties of evaluating social enterprises poses serious problems for rigorous quantitative analysis of the field (CASE, 2008). The regulation of such enterprises also suffers as neither markets nor governments are properly equipped to fulfil this role.

Finally, the construct of social entrepreneurship itself is not without critics. Zahra et al (2009: 520) argue that “the application of organizational models that stress competitive practices is incongruent with, and even dangerous to, the values of the traditional social models, which emphasize community participation, transparency, due process and stewardship”. There are also concerns regarding the accountability of the actors involved in the application of new and untested organisational models and frameworks (Zahra et al, 2009: 527). This, however, is likely to resolve in time as social enterprises become more mainstream and regulation and legal structures adapt to their presence.

2.2 Social Entrepreneurship – Development Implications for Africa

2.2.1 The Context and Traditional Approaches

The World Bank’s (2004) World Development Report concludes that access to, as well as quality and affordability of, services designed to meet basic human needs such as sanitation, healthcare and education is inadequate for many of the world’s poor. As Seelos and Mair (2005a: 242) argue, the “main reason for this failure appears to be the fact that public spending does not reach the poor and, if it does, service provision is often inefficient and of poor quality”. Although performance across the continent varies substantially, Kenya is no exception. Despite the focus given to address inequality, poverty and the provision of basic goods and services, many of these issues remain far from being resolved.

Foreign aid, restructuring programmes, government interventions and policy reforms have also achieved less than was anticipated or is needed (Stiglitz, 2002). The “realization that decades of experimentation and large-scale efforts of multilateral development organizations have not revealed any replicable designs that would enable sustainable economic development on a truly global scale reflects Brundtland’s (1987) concerns at the lack of a blueprint for sustainability” (Seelos & Mair, 2005b: 4). While none of these more traditional approaches should necessarily be stopped, the challenge still remains to find effective and sustainable solutions to some of the continent’s most pressing social problems. Many solutions to these issues often demand fundamental transformations in political, economic, and social systems. Because of this complimentary approaches that seek innovative, efficient and sustainable models to tackle these problems outside of the traditional channels are proving valuable (Alvord, Brown & Letts, 2004).

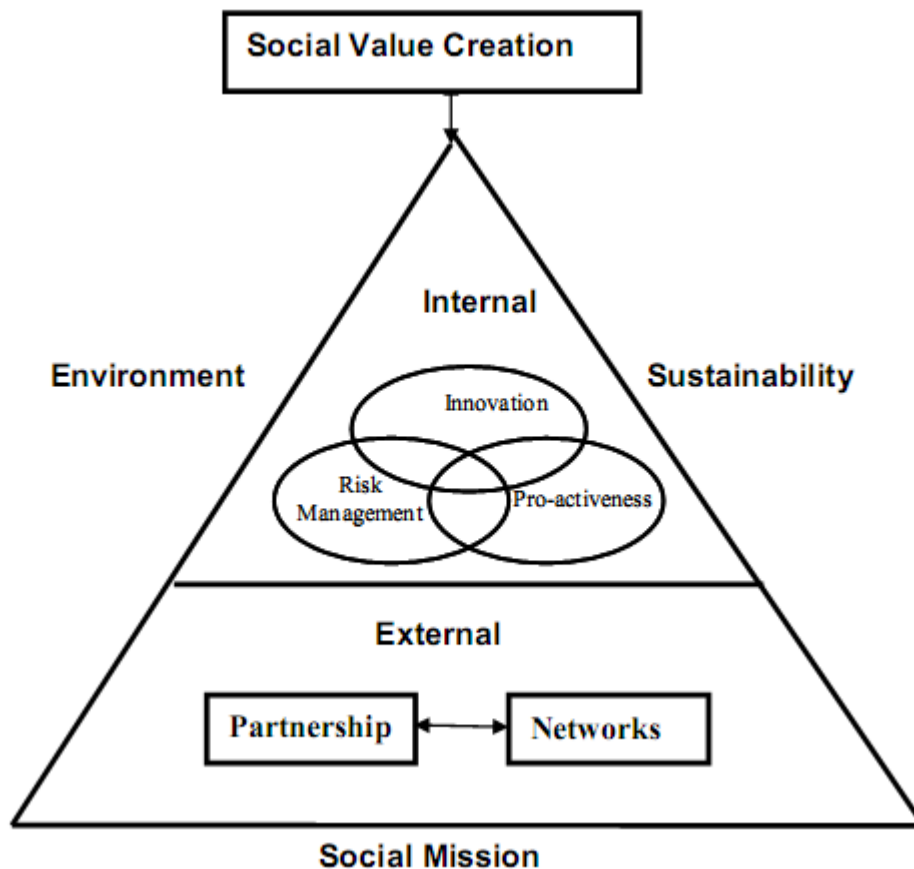
2.2.2 The Role and Scope of Social Entrepreneurship for Social Development

Social enterprises are uniquely positioned to address many of the unmet needs in society as their focus on innovative, risk-managing, pro-active and sustainable solutions increase the chances of success. Alvord, Brown & Letts (2004) look at social entrepreneurship and its long-term impacts on poverty alleviation and societal transformation. They note that while in many cases replication or expansion of existing services does not require social entrepreneurship, “when the resources or capacities to duplicate existing services for poor and marginalized groups are not available, creative initiatives can reconfigure existing resources or services for more effective or wider delivery” (Alvord, Brown & Letts, 2004: 263).

Social enterprises have the potential to create both social and economic value through 1) meeting social needs in new, innovative and often more sustainable ways than alternative approaches; 2) generating employment opportunities and increasing net productivity in a country; 3) developing social capital, which further enhances social and economic development; 4) promoting equity through the focus placed on the needs of disadvantaged and vulnerable members of society and 5) creating cross sector partnerships (Ngosiane, 2010; Nagler, 2007; Seelos & Mair, 2005a). The multiplier effects of all these benefits also increase total societal wealth and wellbeing.

As captured in Rametse and Shah’s (2013) adapted model below, the role of a social enterprise’s social value creation is driven by internal characteristics such as innovation, risk management and pro-activeness as well as by external relationships with surrounding networks and the partnerships it develops. The scope of the resulting impact is determined in part by its social mission, its potential and design for sustainability as well as by the environment in which it operates (i.e. legal, political, regulatory and economic factors).

Figure 1: Factors driving and limiting the social value creation of social enterprises



Source: Rametse & Shah (2013), adapted from Weerawardena and Mort (2006:32)

Opportunity Identification and Innovation

One of the key characteristics of social entrepreneurship is its ability or aim to address unmet needs through opportunity identification and innovation to develop new goods and services (Nagler, 2007). As Neck, Brush & Allen (2009: 16) explain, “solutions to social problems such as healthcare, education, poverty, and hunger - as well as new technologies and innovations - are opportunity spaces, as are solutions to environmental problems such as energy, water, and global warming”. These innovative solutions can remain an isolated approach to addressing a central social issue or can scale in different ways, sometimes ending up changing local, regional or national policies and procedures in a given sector. It is important to recognise that meaningful scale takes time to achieve and that “market-based solutions, therefore, are not a quick fix to the causes and consequences of poverty, though they promise large, enduring benefits” (Karamchandani, Kubzansky & Frandano, 2009: 5).

The pioneering nature of many social enterprises often means that new models and products are developed and made available in societies that previously did not have access to them (Drucker, 1985). The efficient mobilisation of resources and creative use of networks allows these new solutions to take root in a developing country setting. One of the challenges faced by social entrepreneurs in this setting is the lack of technological innovation, which constrains some of the potential impact. The growth of ventures applying existing technology in new ways and in new sectors, makes up for some of this deficit, although an effort to increase the capacity for technological advancement would help develop the scope for innovation and impact of social enterprises in Africa (Rametse & Shah, 2013)

Pro-activity

Another key driver of impact in the social entrepreneurship framework is the proactive nature of entrepreneurs to continuously find new models and solutions to address social issues and adapt to the changing environment in which they find themselves. As Rametse and Shah (2013: 98) argue, “entrepreneurial organizations must be bold and aggressive in pursuing opportunities and initiating actions in order for a social enterprise to be effective in creating social value”. The enterprise’s opportunity identification and innovation process must also be followed by careful planning and implementation if the positive gains are to be realised.

Sustainability

Sustainability is an important focus of social entrepreneurship as it allows the enterprise to ‘survive’ whilst pursuing its social mission. The decline of donor funding pushes organisations to start looking for ways to achieve their social missions whilst developing internal financial sustainability. While some social enterprises incorporate donor funding into their model, the aim is to build in a measure of financial independence that reduces vulnerability to changes in supplies of funds from donors. This is becoming especially important in the current turbulent economic environment faced all over the world but particularly in Africa where instability, uncertainty and lack of resources threatens sustainability (Rametse & Shah, 2013: 98). As such, many social enterprises prioritise sustainability over growth. This also encourages emphasis to be placed on risk management and mitigation. Whereas many business enterprises endure risk in order to receive potential financial returns, social enterprises are constrained by a lack of investors willing to take on similar levels of risk without the offer of such returns. As the returns to social entrepreneurship are often hard to value or capture individually, risk taking to

achieve social returns is not well as supported by investors as traditional profit seeking ventures (Rametse & Shah, 2013). Although more social venture capital and philanthropic funds are emerging to support these enterprises, social enterprises still need to manage risk carefully to promote long-term sustainability.

Employment

An off-spin of social enterprises is their capacity for job creation, not only for the entrepreneur but also for any staff hired by the enterprise and for supply chain businesses that grow in order to service the needs of the enterprise (Nagler, 2007). This improves social wealth through net increases in productivity and higher standards of living for employees and beneficiaries of social enterprises (Ngosiane, 2010). In addition to the economic benefits, Nagler (2007) further proposes that increased social entrepreneurship develops social capital and drives a society towards greater equality by integrating disadvantaged groups into the labour force and providing affordable goods and services to the poor.

2.2.3 Environmental Constraints to Success

Despite the general consensus of the positive role social enterprises can play in advancing social development across Africa, many constraints still exist that limit their scope for impact. Environmental constraints include barriers from the local political, economic, social and cultural milieus that these enterprises are located within. Such barriers influence the social enterprises' ability to pursue specific goals, follow regulatory processes for operating, access necessary supply chains, acquire finance and fit into the community (Rametse & Shah, 2013). Understanding these constraints is important both for the entrepreneurs who need to operate within the environment and for policy makers who can help ameliorate the constraints in order to promote the development of social entrepreneurship within their country.

Some of the key examples of environmental constraints facing social entrepreneurs in many countries are captured below.

Economic Constraints

One of the biggest constraints to the establishment and success of social enterprises is the limited access to finance that is appropriately structured for their specific needs (Open Capital Advisors, 2012). Many formal financial institutions see social enterprises, especially the smaller ones, as too risky or unprofitable to finance (Rogerson, 2001: 127). Where access to finance through local markets exists, it is often time-consuming and challenging to get (Open Capital Advisors, 2012). Although more social venture funds are backing enterprises with social missions, acquiring funding through this channel can be extremely competitive and difficult to secure.

Market failures and inefficiencies that limit growth are rife in many African economies (Open Capital Advisors, 2012). These include, but are not limited to, information asymmetries caused by limited transparency, lack of audited financial statements, inability to provide collateral and limited third party credit scoring information available. The local financial markets are often underdeveloped and ill-equipped to deal with these inefficiencies. This undermines their ability to support the creation and growth of new social enterprises.

The problem of high fixed costs (accompanied by smaller investment size and low turnover amounts) means that commercial viability or financial sustainability is hard to achieve (Karamchandani, Kubzansky & Frandano, 2009). Few African countries have tried to implement policies or programmes to help (or incentivise) social entrepreneurs to overcome this challenge.

Political constraints

Lengthy bureaucratic processes for setting up enterprises create costly delays and act as a deterrent to those wishing to enter the social entrepreneurship space (Ngosiane, 2010). Corruption similarly drives up the costs of starting or running an enterprise, which is particularly detrimental for an entity who aims to keep costs down for its consumer and create a sustainable model for operating with sometimes limited revenue. Political instability also increases the uncertainty and risk levels faced by social entrepreneurs, which can undermine their success (Rametse & Shah, 2013). Although these challenges are not unique to social enterprises, it often affects them more severely due to their tighter margins and financial constraints.

Cultural and Social Constraints

Cultural constraints such as gender biases or decision making power norms in particular societies can influence the ability for social enterprises to connect with or impact local communities (Rametse & Shah, 2013). Karamchandani et al (2009) notes that the priority of offering a low cost product or service makes it challenging for an individual enterprise to absorb the significant customer education costs required to stimulate demand for or awareness of that product or service.

Another significant constraint for social enterprises is the struggle to attract talented or adequately trained employees, especially for managerial positions (Open Capital Advisors, 2012). This is particularly difficult in the case of skilled labour professionals as the importance of keeping prices low for the end consumer in a social enterprise leaves little scope for paying high or attractive salaries for these professionals who could command much better pay in another sector (Karamchandani et al, 2009). Creativity in attracting and retaining the necessary talent to make the enterprise a success is a central consideration for social entrepreneurs.

Capacity Constraints

In addition to the economic constraints listed above, the inadequate infrastructure in many African countries further increases the cost of doing the business and limits the scope of the social enterprise (Ngosiane, 2010). It also acts as a barrier to distribution, especially for accessing the rural poor with a particular good or service (Karamchandani et al, 2009). There is also rarely the sufficient capacity development support for new or growing social entrepreneurs, which would help improve the chances of success and meaningful impact (Open Capital Advisors, 2012).

2.2.4 Improving the Path Forward

Considering the potential social entrepreneurship has for development in Africa and the constraints it faces, it is important to look at ways in which an enabling environment for social enterprises can be fostered. UNCTAD (2012), in its framework for social entrepreneurship policy, identify three levels of policy support that can help achieve this. The first is to improve the general business climate through broad reaching economic policies. This would include

“minimising regulatory barriers, administrative and compliance costs and tax burdens, and ensuring functioning markets, competition, and the effectiveness of bankruptcy laws” (Nagler, 2007: 8). The second is to develop policies to promote private sector and enterprise growth. The third is to create specific policies to increase entrepreneurial capacity and facilitate start-ups. Reducing regulation and creating specific incentive programmes for social enterprises would help achieve this (Nagler, 2007: 7).

More specifically, the following 6 priority areas were proposed. Although each of these would have to be tailored to the specific economic and social context of individual countries, they provide a framework for action. They are: “(1) formulating national entrepreneurship strategy; (2) optimizing the regulatory environment; (3) enhancing entrepreneurship education and skills; (4) facilitating technology exchange and innovation; (5) improving access to finance; and (6) promoting awareness and networking” (UNCTAD, 2012: 2).

Providing financial support for social enterprise development is also a key element in promoting the success of social entrepreneurship for development. As social enterprises generate social value, society at large would benefit from investing in them to enhance their capacity for impact (Taylor & Srot, 2010). This could initially be driven by the public sector, which has a particular mandate to prioritise social welfare and would help “offset the cost of risk that is not intended to result in profit” (Taylor & Srot, 2010: 4). If this approach was adopted, it would become even more important to have good measurement of social impact to make sure it outweighs the costs involved.

Other steps, such as creating supportive institutions and legal structures, including a legal mandate for recognition of an entity as having social enterprise status and encouraging best-practice exchange and training through social entrepreneurship centres, could also help improve the path forward (Taylor & Srot, 2010; Nagler, 2007). Through these initiatives, a healthy institutional, economic and social environment can be developed to support the growth of social entrepreneurship in developing countries. The strength of this ecosystem will significantly determine the extent to which the practice of social entrepreneurship can be a force for positive social development in Africa (CASE, 2008).

2.3 The Kenyan Ecosystem for Social Entrepreneurship

2.3.1 Policy and Regulation

Policy at a national level plays an important role in shaping the potential for social enterprises to achieve impact. Micro, Small and Medium Enterprises (MSMEs) as a broader category provided 78% of total employment and accounted for more than 57% of new job creation in Kenya during 2005-2006 but over 80% operated outside the formal economy (Taylor & Srot, 2010: 8). According to World Bank's Doing Business Report (which looks at structural regulations and processes that enable or hinder business activity), while Kenya ranks 5th for facilitating credit loans, it places 109 out of 181 countries for ease of starting a business and 158 out of 181 for ease of paying taxes (World Bank, 2009). Although this refers directly to the business sector, social enterprises are also affected by these regulations.

In an effort to combat the cumbersome regulatory environment for new enterprises, a Business Regulations Reforms Unit was formed in 2005 that started an initiative to review licenses that regulated business at the time (Taylor & Srot, 2010: 8). By the end of 2008, "315 licenses had been eliminated, 379 simplified, 294 retained, and 26 prioritized for reform" (Taylor & Srot, 2010: 8). The time needed to start a business fell from 54 days in 2006 to 34 days in 2009 (World Bank, 2009). Despite these initiatives and the progress made, as of 2010 there were 12 processes that needed to be undertaken to start a business, amounting to a cost of 39.7% of average Gross National Income per capita (World Bank, 2009). Taylor and Srot (2010: 8) argue that "business regulations at a municipal level are often implemented in a discretionary and inconsistent way – especially the Single Business Permit (SBP). SBPs are a municipal operating licence for business, but they are often used as mechanism to raise municipal revenue rather than as a means to regulate business entry and activities in a constructive way. The SBP system was introduced in 2000 to replace a multitude of business licences, yet it has failed to do so in practice as local authorities use bylaws to reintroduce licences eliminated by the SBP.

The Private Sector Development Strategy (PSDS) (2006-2010) is a plan to "catalyse the provision of an enabling environment which will enhance private sector growth and competitiveness" (Ministry of Trade and Industry, GoK, 2006: x). This is done in the hope that, "while pursuing their corporate interests, businesses will respond to incentives created

through the PSDS, not only to meet their profit goals, but also to help Kenya reduce poverty and enjoy a higher economic growth rate” (ibid).

The PSDS was designed to help address some of the main constraints faced by the formal and informal sectors that the strategy identified. These included “corruption, poor infrastructure, high and numerous taxes and tax administration, crime and insecurity and access to finance” as well as limited access to markets, credit and skilled labour for specifically MSMEs (Ministry of Trade and Industry, GoK, 2006: xi). In order to achieve goal 5 (supporting enterprise development), 5 further priorities were adopted: “1) facilitating the development of new enterprises; 2) improving access to capital; 3) facilitating the graduation and evolution of enterprises; 4) promoting firm-to-firm linkages, and (5) promoting broader MSME representation in business associations” (Ministry of Trade and Industry, GoK, 2006: xiii). Limited work has been done to assess the success of these measures since adoption.

In order to promote the Government of Kenya’s (GoK) overarching mission of becoming a “globally competitive and prosperous nation with a high quality of life by 2030”, a long-term development blueprint for the country was created called Kenya Vision 2030 (Government of the Republic of Kenya, 2007). Kenya Vision 2030 is centred on three key pillars: Economic; Social; and Political Governance. The objective of the economic pillar is to achieve and sustain an economic growth rate of 10 per cent per annum through the implementation of several flagship projects in 6 priority sectors. These are Tourism, Agriculture, Wholesale and Retail Trade, Manufacturing, Business Process Outsourcing (BPO) and Financial Services (Government of the Republic of Kenya, 2007). The social pillar aims to create “a just, cohesive and equitable social development in a clean and secure environment” through comprehensive social interventions designed to improve the quality of life (Government of the Republic of Kenya, 2007). Finally, the political pillar objective is to have “an issue-based, people-centred, result-oriented and accountable democratic system” (Government of the Republic of Kenya, 2007).

The regulation in the microfinance sector, as one of the enabling industries for many social enterprises, has an indirect but substantial effect on the prospects for social entrepreneurship in Kenya. As Omino (2005: 5) identifies, the “major impediment to the development of microfinance business in Kenya is a lack of specific legislation and set of regulations to guide the operations of the sub-sector.” He argues that this lack of appropriate regulatory oversight has contributed to poor performance and the “eventual demise of many

microfinance institutions” (Omino, 2005: 5). Without the support structures being properly regulated and encouraged, social enterprises face many difficulties in daily operations.

While the focus on enterprise development and enabling factors for private sector development will improve the operating environment of social enterprises, it still leaves a gap in national policy that directly engages with the social potential of the sector. The majority of national policy and regulation refers to the economic and social sectors independently with very little directly addressing social entrepreneurship. Despite the growth of social enterprises across Kenya, there is almost no mention of social entrepreneurship or efforts to support them in the revised priorities, goals and thematic foci of the second stage of Kenya Vision 2030 (Vision 2030, 2013).

2.3.2 Support and Service Infrastructure

Very little internally developed support infrastructure exists for social entrepreneurs in Kenya. Social venture supporters such as Ashoka, the Acumen Fund and Schwab Foundation all have bases in East Africa and operate in Kenya, providing support, funding, mentorship and advocacy for social entrepreneurs. None of these, however, are Kenyan specific but rather are international social entrepreneurship organisations that have identified Kenya as a country with potential.

Region specific organisations that support the emergence and growth of social entrepreneurship across East Africa, and Kenya in particular, include the East African Social Enterprise Network (EASEN) and SocEntLab. EASEN is a membership organisation that serves as a single entity to bring social enterprises in the region together in order to network and develop the sector (Trickle Out Project, nd). Their strategic objectives include advocacy, business development services, mobilisation of financial resources and advisory services. The SocEntLab is a social enterprise and think tank based in Nairobi. It started in 2011 with the aim of building an eco-system for entrepreneurship in Africa (SocEntLab, 2013). Their work involves impact investing, incubator programmes for new social enterprises and capacity building for start-ups, education providers and cooperative organisations.

2.3.3 Operative Environment

The operative environment can either enable or hinder the ease with which everyday procedures of an enterprise occur. The existing infrastructure (both physical and technological) is particularly significant for operations. In Kenya, improving the physical infrastructure is a priority area for the Government. While progress has been made in developing new transportation networks, the poor quality and limited reach of many of the existing infrastructure networks remains a challenge (Vision 2030, 2013: 19). This operating environment impacts the access for clients to the social enterprise's services as well as the supply chain logistics of the enterprise itself.

An area in which Kenya is currently thriving is in the emergence of information and communications technology. The use of mobile phones for financial transactions and collaboration (for example Mpesa, iHub & mLab) has allowed social enterprises to create new processes and ways of developing models, products and services to meet the needs of society. This is possible because of the high penetration levels of mobile phones in the population.

A gap in the literature exists detailing the enabling and hindering aspects for social entrepreneurship created by the local culture and attitudes of the general population.

2.4 The Health Sector in Kenya

“The Kenyan Constitution 2010 through the Bill of Rights puts a heavy responsibility on the health sector to ensure realization of the right to health. The goal for the health sector is to provide equitable, affordable and quality health care to all citizens.

Healthcare is essential for the socio-economic development of a nation and it has been at the top of public policy agenda since Kenya’s independence. Making healthcare services accessible to everyone remains a great challenge to the existing healthcare system in the country.

Kenya, like other developing nations, has health facilities which are concentrated in the urban areas. Furthermore, throughout the country, some categories of health workers are more concentrated in urban and private sector services. But, with most of the population living in rural areas, creating equitable access to comprehensive health care services including for emergency care is one of the most important aspects in planning an effective health care system.”

- Prof. Fred H.K. Segor | Principal Secretary
(Ministry of Health, 2014: 5)

2.4.1 Background and Context

Demographics and Health Situation

The health sector plays a key role in promoting economic growth and reducing poverty. This is reflected in the Millennium Development Goals (MDGs) of which three out of the eight focus directly on health and another one on affordable drug access (TI, 2011). In order to promote universal and equitable healthcare, governments agreed to set aside 15% of the national budget for the health sector in the Abuja Declaration of April 2001. Most nations are still far from this target. High income countries spend an average of 7% and low income countries spend an average of 4.2% of Gross Domestic Product (GDP) on healthcare (TI, 2011). Total expenditure on healthcare (THE) in Kenya is 4.7% of GDP (WHO, 2013). Table 2 below shows a number of key health statistics for Kenya. Unless otherwise indicated, these figures are for 2009 (WHO, 2013).

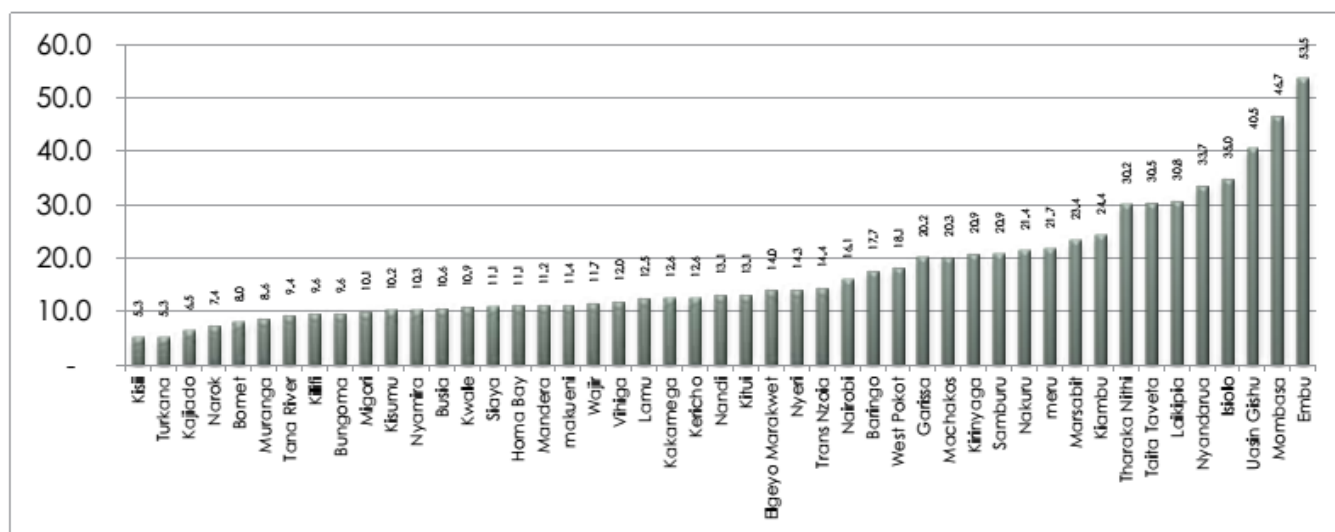
Table 2. Kenyan health statistics

<i>Total population</i>	43, 178, 000
<i>Gross national income per capita (PPP international \$)</i>	1, 710
<i>Life expectancy at birth male/female (years)</i>	58/61
<i>Under five mortality rate (deaths per 1 000 live births)</i>	73
<i>Total expenditure on health as % of GDP (2011)</i>	4.5
<i>Total expenditure on health per capita (PPP intl \$, 2011)</i>	77
<i>Government expenditure on health per capita (PPP intl \$, 2011)</i>	30.5
<i>Government expenditure on health as % of total government expenditure (2011)</i>	5.9
<i>Human Development Index rank out of 186 (2013)</i>	145

Kenya has a high prevalence of communicable disease, which places a major burden on the health system as well as the economy at large. The human immunodeficiency virus (HIV) incidence is currently approximately 6.3% (Kenya Demographic and Health Survey, 2008-09). There is a high prevalence of Tuberculosis (TB) infection as well as a co-infection rate of 45% for TB and HIV (ibid). The large majority (83%) of those infected do not know their HIV status, and only 35% of those in need of anti-retroviral therapy (ART) are accessing treatment (Kenya AIDS Indicator Survey, 2009). Malaria is ubiquitous among adults living in malarial areas and is the leading cause of morbidity in the country (30%) (MoPHS, 2008).

In light of these health challenges, ensuring access to and utilisation of health services is a vital component of improving health outcomes in Kenya. Although utilization of health services among the population is increasing, access to quality health care is still limited for a large number of people. The primary barriers to access are geographical and financial. Significant divides exist in healthcare access and quality between rural and urban communities as well as between the moneyed elite and the poorer masses. The latter constitute approximately 52% of the population, determined as those living under the national poverty line (Turin, 2010). Figure 2 shows the substantial difference in concentrations of healthcare staff across Kenya's different counties, indicating the disparate access to healthcare professionals that currently exists.

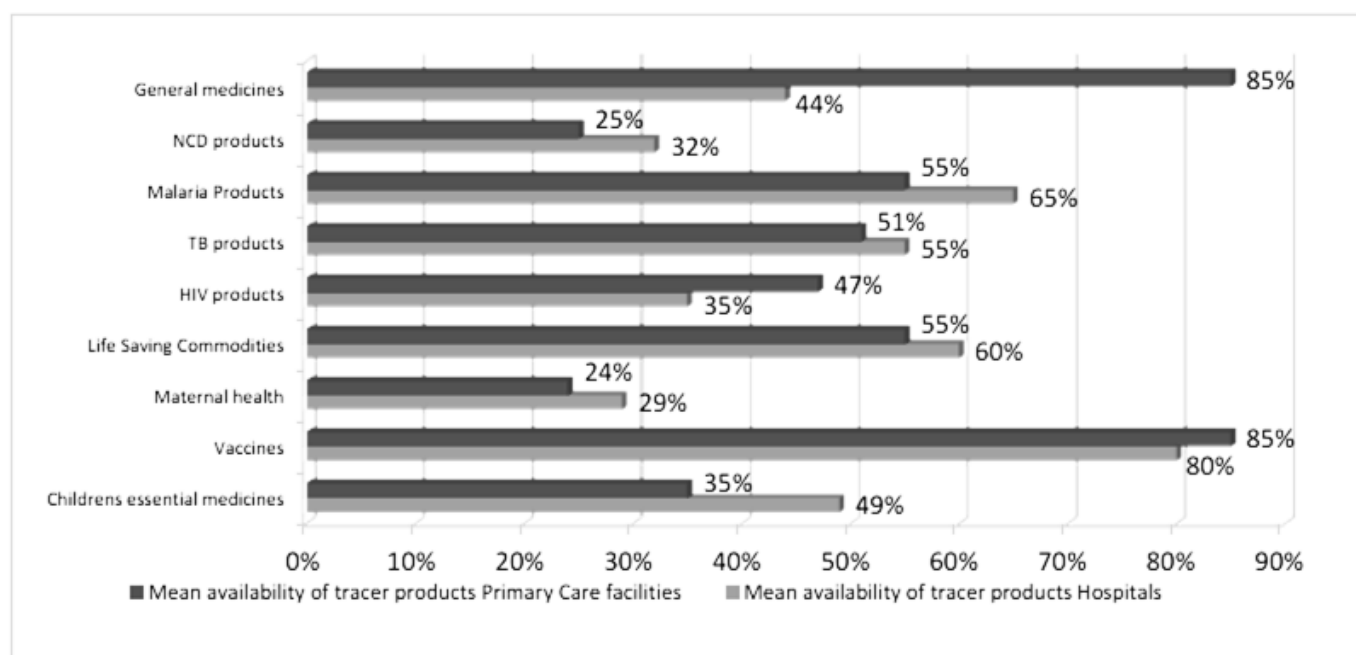
Figure 2. Total staff per 10 000 population, by County



Source: GoK, 2014: xvii

The availability of health products and services is also a big concern. Figure 3 shows the mean availability of products for various priority outcome areas in primary health facilities and hospitals. While vaccines and general medicines in primary care facilities tend to be readily available, maternal health and non-communicable disease products are the least available for both primary care facilities and hospitals (GoK, 2014: xvii).

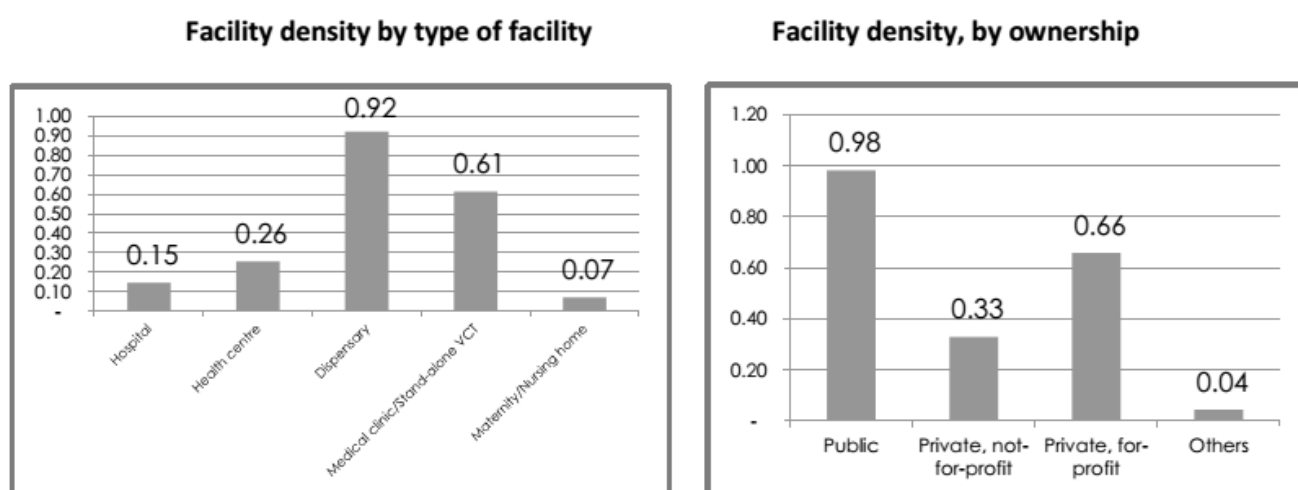
Figure 3. Mean availability of products for different programme areas



Source: GoK, 2014: xvii

While the state provision of health services is substantial, the widespread gaps in the system are filled by a range of private providers. These include faith-based organisations (FBOs), NGOs, and for-profit entities. Figure 4 shows the national average facility density (NAFD) per 10 000 population. The total NAFD is 2.04 (GoK, 2014: xvi).

Figure 4. National average facility density per 10 000 population by type and ownership



Source: GoK, 2014: xvi

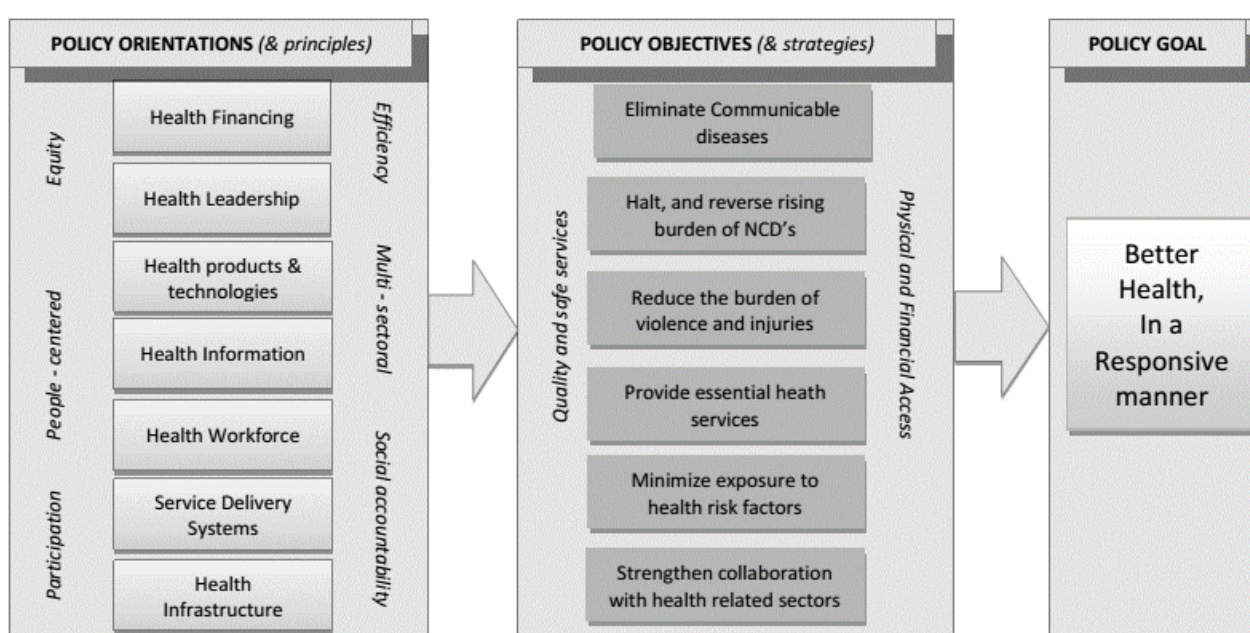
The GoK undertook a Service Delivery and Readiness Mapping exercise (SARAM, 2014) to assess the capacity of the health facilities to provide health services. The readiness in this aspect showed the basic requirements to provide services such as infrastructure, amenities, basic equipment, standard precautions for infection control, diagnostic tests, medicines and commodities (GoK, 2014: xviii). They found that the service readiness index was 57% - implying that 57% of all health facilities are ready to provide Kenya Essential Package for Health (KEPH) services. Based on the readiness variables, 47% have the basic amenities to provide services; 67% have the basic equipment required, 41% have essential medicines and 73% have the standard precautions (ibid). Private not-for-profit facilities have the highest general readiness index (65%) compared with the public (57%) and private for-profit (54%) (ibid). Looking at specific services, facilities are most ready to provide Malaria, HIV/AIDS and TB services, and least ready to provide maternal health and non-communicable disease (NCD) services.

Considering the health situation in Kenya where increasing demand for care coupled with inadequate funding, underdeveloped infrastructure, insufficient product availability and shortages in human resource capacity, substantial investments in the sector are needed.

Approach and Priorities on a National Scale

The Kenya Health Policy (KHP) is a guide to attaining the long term health goals outlined in the Vision 2030 and the 2010 constitution. The overarching goal is to attain ‘the highest possible health standards in a manner responsive to the population needs’ (GoK, 2014: 4). This will be pursued through supporting the provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans (ibid). Figure 5 below shows the interlinked policy investment areas and objectives laid out to achieve the overarching goal.

Figure 5. Framework for policy directions



Source: GoK, 2014: 4

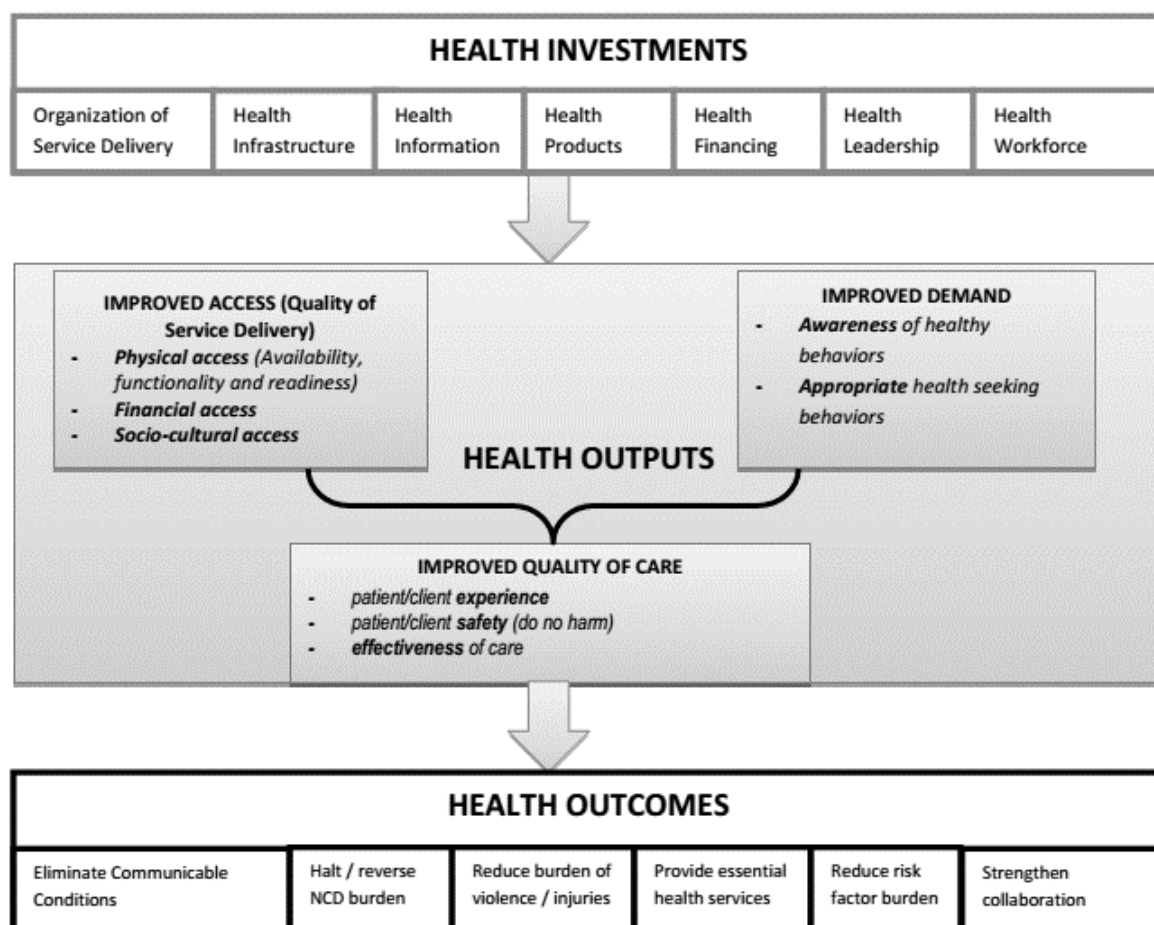
The six policy objectives from the framework are elaborated below, with strategies for attainment stated that are in line with the KHP and its goal of universal health coverage.

1. *Eliminate communicable conditions*: by forcing down the burden of communicable diseases, till they are not of major public health concern.
2. *Halt, and reverse the rising burden of non-communicable conditions*: by ensuring clear strategies to address all the identified non-communicable conditions in the country.
3. *Reduce the burden of violence and injuries*: by directly putting in place strategies that address each of the causes of injuries and violence at the time.

4. *Provide essential health care*: These shall be medical services that are affordable, equitable, accessible and responsive to client needs.
5. *Minimize exposure to health risk factors*: by strengthening the health promoting interventions, which address risk factors to health, plus facilitating use of products and services that lead to healthy behaviours in the population.
6. *Strengthen collaboration with health related sectors*: by ensuring the Health Sector interacts with and influences design implementation and monitoring processes in all health related sector actions (GoK, 2014: 4-5)

The following three output areas will be the focus for achieving the service delivery outcomes listed above: 1) Improving access to health services (physical, financial and socio-cultural); 2) Improving demand for health services; and 3) Improving quality of care (GoK, 2014: 5). Figure 6 shows how these three outputs are supported by health investments and flow towards the priority health outcomes as portrayed by the Kenyan Ministry of Health (MoH).

Figure 6. Linkages between health outputs, investment and outcomes



Source: GoK, 2014: 6

Administrative System and Delivery Model

The Kenyan healthcare system is a hierarchical structure administered from the top down by the MoH. Health facilities are distributed regionally with the most sophisticated services available in the major cities or at the national level (at the National, Referral, and Teaching Hospitals (NRTTH) such as the Kenyatta National Hospital in Nairobi).

Basic care is provided at primary healthcare centres and dispensaries. Dispensaries are run and managed by enrolled and registered nurses who are supervised by the nursing officer at the respective health centre. They provide outpatient services for simple ailments such as the common cold and flu, uncomplicated malaria and skin conditions. Those patients who cannot be managed by the nurse are referred to the health centres (Allianz, 2013). Due to inadequate knowledge on the organisation of services and the perceived low quality of services offered at lower levels, clients often by-pass available services at those lower levels where services could be provided more cost effectively (MoH, 2014b: 7).

Sub-district, district and provincial hospitals provide secondary care, comprised of integrated curative and rehabilitative care. Sub-district hospitals are similar to health centres with the addition of a surgery unit for Caesarean sections and other procedures. District hospitals usually have the resources to provide comprehensive medical and surgical services. Provincial hospitals are regional centres which provide specialised care including intensive care, life support and specialist consultations (Allianz, 2013).

Third level care is provided at the general hospitals (NRTTH) Moi and Kenyatta, both located in Nairobi. These operate as academic hospitals that pursue research, provide clinical training, offer high levels of care and are mostly only accessible to the general public through a developed referral system - when a patient enters a public facility, they will be treated or referred to the next level of care depending on the severity of the case. Generally, the higher the level of the referral chain, the more specialised the staff and the more resourced the facilities (Muga, Kizito, Mbayah, & Gakuruh, 2005).

The Kenyan healthcare system is also significantly influenced by non-governmental provision of health services by NGOs, FBOs and private health facilities. In 2008, the GoK operated 48% of the country's health facilities, with NGOs/FBOs operating a combined 15% (13% FBO, 2% NGO), and the private for-profit sector operating 34% of all facilities (MoPHS, 2008). Although the private health facilities generally offer a better standard of care compared to similar public facilities, the high cost of treatment makes it prohibitive for the majority of

Kenyans (Turin, 2010). The private sector provides mainly curative health services and very few preventive services.

It is widely acknowledged among the public, not-for-profit and private commercial health providers that “each play an important role in the overall health market, although the importance of each varies significantly by region and by the type of services or products being offered” (Barnes et al, 2010: 11). Despite this, very little strategic analysis has been done to coordinate how each sector can best contribute to meeting the country’s health needs (ibid). In particular there is overlap in, and competition, for the provision of health care for middle and upper income groups with many consumers in the rural areas and lower incomes groups remaining underserved. Additionally, with few exceptions (e.g. TB), there is “little formal policy that guides whether and how public sector and private sector providers can share access to diagnostic equipment, training resources, subsidized donor commodities, and health data” (Barnes et al, 2010: 13). Table 3 shows the breakdown of health service delivery by sector.

Table 3. Service Delivery: Facilities and Human Resources

Type of Service	Public	Private ⁶				Total
		For-profit	Not-for-profit, NGO or Unknown	FBO	Total Private	
Facilities*						
Tertiary Hospitals (level 6)	4	0	0	0	0	4
Secondary Hospitals (level 5)	10	0	0	0	0	10
Primary Hospitals (level 4)	225	12	5	23	40	265
Other Hospitals (level 4)	22	41	59	52	152	174
Health Centers (level 3)	473	21	88	139	248	721
Dispensaries (level 2)	2393	74	380	509	963	3356
Nursing Homes (level 3)	3	89	54	9	152	155
Clinics (level 2)	20	1126	693	102	1921	1941
Laboratory – Stand alone	0	52	2	0	52	52
Stand-alone VCT clinics	7	2	29	7	38	45
Dental Clinics	0	10	1	0	11	9
Registered Medical Personnel**						
Doctors	1,715	5,182				6,897
Clinical Officers	2,116	3,772				5,888
Nurses	14,958	32,907				47,865
Pharmacists/Pharmaceutical Technologists	652	4,219				4,871
Public health Officers/Public Health Technicians	4,027	9,134				13,161

Source: Luoma et al (2010: 10)

Private Provision of Healthcare

Private provision of healthcare in Kenya represents a substantial proportion of the country's health services. The private sector owns and operates almost half of all health facilities. Despite this, there is a severe lack of engagement between the MoH, donors and technical experts and the private health sector. This undermines the potential to collaborate in order to harness innovation and mitigate market failures (Dimovska, Sealy, Bergkvist, & Pernefeldt, 2009). There is also insufficient consultation between the Ministry of Health and the private health sector in terms of policy formation and coordinating responses to specific health problems. Additionally, the laws to deal with malpractice in the private health sector and the regulation of the private provision of health services in Kenya are inadequate (Muthaka, Kimani, Mwaura & Manda, 2004).

In order to improve health systems, especially in the face of constrained national resources and capacity, it is becoming increasingly important for developing countries to integrate traditional government health care with the large and growing private health sector, where similar or complementary services are offered. Kenya with its mixed health system is no exception. While many studies have documented the public health sector's shortcomings, very little systematic and broad coverage evidence exists on the relative quality and efficiency of private health care provision in Kenya.

The structure of the private health sector is asymmetrical, with a small number of large, successful private providers who own hospitals and clinics that offer high-quality services, concentrated mainly in Nairobi, Kisumu, and Mombasa. On the other end of the spectrum is a high concentration of small-scale providers at primary care facilities that often struggle to remain financially viable and whose quality varies. These predominantly cater to the health needs of lower-to-middle-income individuals. As Barnes et al (2010: 9) note, "this gap in the middle range of private facilities has implications for the effectiveness of referral systems and continuity of care in the private sector: the absence of private secondary care facilities means that private primary care providers have few options for referrals other than to send patients to public sector providers". This becomes problematic when public facilities do not accept the diagnoses made by the private providers and require patients to begin the consultation process over again (Barnes et al, 2010: 9). Policy detailing the procedures for referrals of patients between public and private health care providers is currently inadequate.

There is a substantial divergence between the characteristics, services provided and challenges faced by the different private sector actors. Company and for-profit health facilities are generally concentrated in urban areas where factors such as the size of the market and the willingness and ability of prospective patients to pay are more favourable for profitability (Berman et al, 1995). Company-provided health is motivated by employers' need to offer health services to employees in order to reduce production losses. These types of providers are usually experienced in management and operations efficiency and are significantly driven by cost considerations and either make a profit or produce company savings and are therefore inherently more financially sustainable.

FBO and NGO providers on the other hand face a number of challenges. The three main ones are 1) financial constraints due to reliance on donor funding or models that substantially trade-off profit concerns with social ones; 2) a lack of management and administrative skills; and 3) a lack of skilled medical professionals due to training space shortages and low incentives to retain workers. Given these constraints, many non-profit private providers battle to be sustainable and effective (Berman et al, 1995). Despite this, they tend to offer the best mix of quality and affordability, making them obvious choice for many Kenyans.

Traditional health practitioners were historically the main providers of health services in Kenya. While the advent of modern medicine has changed the healthcare landscape, many still operate as key providers in this sector, especially in rural areas. Most operate on a fee-for-service basis and include herbalists, diviners and bonesetters (Berman et al, 1994). Traditional practitioners in Kenya are not however regarded as medical practitioners, which hinders their proper regulation (Muthaka et al, 2004).

Financing Healthcare

The overall health financing situation in Kenya is characterized by inadequate funding, an underdeveloped health services infrastructure and limited administrative and management capacity. This restricts health service delivery and coverage and reduces the sector's ability to ensure an adequate level of healthcare for the population. The provision of health and medical care services in Kenya is therefore partly dependent on donors who regularly provide around 15-30% of the total expenditure on healthcare. According to Kenya's National Health Accounts (NHA) for 2000-2001, the government (both central and local) contributed 30% of Kenya's healthcare costs, households paid 51% out of pocket, donors (domestic and international)

supplied 16% and the statutory National Hospital Insurance Fund (NHIF) along with other private insurers and sources cover the rest (Wamai, 2009). A decade later, the donor proportion has risen to 31% while household expenditure has dropped to approximately 36% (Luoma et al, 2010: 17). Despite primary care facilities providing the bulk of health services in a cost effective manner, the health budget allocation is skewed in favour of tertiary and secondary care facilities, which absorb 70 percent of health expenditures (Muga et al, 2005: 24).

In terms of health insurance in Kenya, there are two broad types of formal insurance: the NHIF and private health insurance. Additionally there are informal risk-sharing arrangements such as Harambee, meaning “all pull together” in Swahili, which is a Kenyan tradition of collective sharing and supporting (Mathauer, Schmidt & Wenyaa, 2008). Approximately 88% of Kenyans with insurance are covered by the NHIF. There is currently very little widespread coverage by private insurers and that which exists is largely limited to those in formal sector employment in urban areas (Berman et al, 1995). A report published in 2010 put the number of privately insured Kenyans at about 600 000, roughly 2% of the total population (Barnes et al, 2010: 29). This is in comparison to the public health insurance (the NHIF) scheme with over 2 million principal members. Although small, the private insurance sector is fairly developed. The Kenyan NHA (2010: 9) identified 44 licensed insurance companies providing both life and general business insurance, of which 21 were medical insurance providers.

Looking at health insurance is important as it affects the demand for private health services by lowering the cash cost of care at the time of illness. It also increases the variety of providers who are financially accessible to the patient (Berman et al, 1995). The level of interest and investment in risk-pooling mechanisms within the health sector in Kenya is growing. As Barnes et al (2010: 29) argue, whether through NHIF, employer-managed plans, or new forms of social health insurance, risk pooling probably offers the greatest opportunity for growth of the private health sector because it increases consumers’ ability to pay for services. However, a number of challenges exist for developing the health insurance market. Barnes et al (2010: xvi) identify some of the key constraints:

- Both consumers and health care providers have poor knowledge and perceptions of health insurance. Consumers generally have a poor understanding of the concept of risk pooling, and the insurance industry has a poor image due to the collapse of several managed-care schemes.

- Most insurers are reluctant to create true risk-pooling products and treat health care like other lines of indemnity insurance due to weak underwriting capacity and overly restrictive regulations that prevent innovation.
- Low-cost, innovative insurance products are uncommon in Kenya. The absence of data on the lower end of the market, lack of underwriting skills needed to develop low-cost products, and need for economies of scale have dampened innovation in this area.
- Fee-for-service is the predominant mode of provider payments in both private and public health insurance. The low use of capitation has been attributed to lack of skills, lack of reliable statistics, negative attitudes by providers, and the low bargaining power of payers.
- Most private health insurance providers do not see significant competition from social health insurance except in the lower market segment. Everyone anticipates that some form of universal or social health insurance scheme will be established in Kenya. Such a scheme will not pose a threat to the middle-to-upper-income segment of the market, but could compete with private insurers' efforts to develop low-cost insurance products.
- Regulatory reform is critical to consolidate and grow the health insurance market. Most private health insurers believe that the most important and complex aspects of health insurance are not covered by the current law, hindering the development of innovative risk-pooling mechanisms. The central issue for reform is whether or not the health insurance laws, and the regulatory agency, should be separate from the structure for regulating other types of insurance.

The NHIF is a social insurance scheme established under the MoH to accommodate and finance the changing healthcare needs of the Kenyan population. Membership of the NHIF is compulsory for formal and voluntary for informal workers. The scheme covers more than 50% of the cost of curative inpatient health care in government (and some private) facilities (NHIF, 2013). A key advantage of the NHIF as a mandatory programme is that it limits adverse selection. In a normal insurance market comprised of higher and lower risk individuals and characterised by information asymmetry, health insurers are usually unable to accurately categorise each individual and charge accordingly. This means lower risk individuals are charged more and higher risk individuals are charged less than what they would be in a market

without information asymmetry. This leads to the lower risk individuals opting out of the market. This tends to drive the price of insurance up as the market becomes more heavily saturated with higher risk individuals, which makes it more costly for both the insurer and the insured. With mandatory health insurance, this adverse selection cycle and consequent price increases is alleviated as individuals with better health prospects are prohibited from opting out ensuring a balanced market. The extent to which the NHIF encourages over-consumption of health services has not been established in any extensive study.

Since independence in 1963, Kenyan healthcare functioned through a predominantly tax-funded system, but gradually introduced a series of health financing policy changes. In 1989, user fees, or ‘cost-sharing’ were introduced only to be eliminated for outpatient health services a year later after rising concerns about social justice. This was short lived when, due to budget constraints, the user fees were reintroduced in 1992. The user fee system was significantly altered in June 2004, when the MoH stipulated that health care at dispensary and health centre level would be free for all citizens, except for a minimal registration fee in government health facilities (Janovsky & Peters, 2006).

2.4.2 Key Stakeholders – Main Players and Networks

As outlined in the World Health Organisation’s (WHO) Country Cooperation Strategy report for Kenya (2009), the country has elaborated a SWAp to health sector coordination and support.

There are 3 categories of health partners:

- 1) **Government of Kenya**, which provides stewardship, coordination and regulation, as well as service provision through a decentralized system (operating at the district, provincial and national levels).
- 2) **Implementing partners**, which comprise all other actors providing health services to Kenyans. These broadly fall into private-for-profit institutions; private-not-for-profit (such as faith-based, nongovernmental and civil society organizations) and traditional health practitioners.
- 3) **Development partners (DPs)**, which comprise all international partners supporting the health sector, including bilateral and multilateral partners, donors, foundations and global health initiative partners. These DPs are organized around the Development Partners for Health – Kenya group, to which WHO is the Secretariat. WHO engages with development partners on financial and technical levels, involving networking, advocacy, collaboration and facilitation for health development.

Other stakeholders include health financing and insurance providers (both public and private), medical industries (drugs, equipment and medical supplies), academics and think-tanks, innovation developers, civil society organizations and consumer groups. Between many of these exists conflicting interests and hence different potential directions for health financing and provision reform to take. For example, the different interests of the pharmaceutical industry, which wants to sell drugs and make a profit, and social health insurance, which needs to contain costs, cannot always be reconciled. The same is true of profit seeking private health insurers and private health service providers on the one hand, and the providers of care for low income or indigent people on the other. These conflicting interests are especially pertinent in a sector where access to quality services is viewed as a basic right from which people should not be excluded on the basis of financial or geographical constraints. Working out where the balance lies to achieve this is a key issue.

Appendix 1 shows some of the organisations and bodies that make up the primary stakeholders within the Kenyan health sector.

2.4.3 Challenges and Opportunities in the Kenyan Health Sector

Challenges in the Kenyan Health Sector

The effective **utilisation** of healthcare services is a key factor for improving health outcomes and indicators in Kenya, both in the short and long term. A recent study suggests that of those who are ill or in need of healthcare, only 77% seek it (Wamai, 2009). Cost and access appear to be the two most common factors. Among those Kenyans who are ill but chose not to seek care, 44% reported being hindered by costs and another 18% by the long distance to the nearest health facility (Allianz, 2013).

Cost is often prohibitive due to the high burden of out of pocket payments required for health services. The Kenyan Health Sector Statistics Report found that households fund 36% of THE in contrast to the combined 29% from the MoH, NHIF, National AIDS Control Council, local authorities and para-statal (MoPHS, 2008). Donors largely provide the rest. The lack of comprehensive medical insurance options also contributes to the financing challenges of the sector.

Access to health care facilities is unequally distributed across Kenya. The Central Province and Nairobi have the best and most easily available facilities while citizens living in

more rural areas may have to travel hours to get to the nearest healthcare service, which is often only a primary care facility or dispensary (Allianz, 2013). Substantial costs are incurred through travel time and expense to visit far away health centres. In 2008, there were 6,190 health facilities in Kenya (16 facilities per 100,000 people or 11 facilities per 1,000 km²) (MoPHS, 2008). On a regional level, the Rift Valley and Western Province have the least number of hospital beds per 100,000 population, with only 13.6 and 15.4 beds per 100,000 population, respectively. This is less than half what Nyanza province has (Muga et al, 2005).

Not only should patients have access to health care facilities but these facilities should be equipped to provide the necessary care or be able to refer upwards for more serious cases. In practice, many rural facilities are often understaffed, under-equipped and have limited medicines. This further disincentivises the utilisation of health resources as patients who travel far and incur costs involved only to have substandard care and limited medication options are less likely to return in the future. In this way the **quality** of past interactions with the health services sector can significantly influence decisions to seek care in the future. It follows that improvements in health services can help increase the utilisation of health resources and better population health indicators.

Socio-economic barriers such as **low levels of education and high illiteracy rates** create a challenge for effective health care provision. This is because these individuals are “less likely to use health insurance or access written information needed for patient compliance—follow prescriptions, for example, or read and understand preventive health messages” (Barnes et al, 2010: 2). In Kenya, 21.5% of females and 12% of males are illiterate, with higher rates of illiteracy concentrated in rural areas (Barnes et al, 2010: 2). This is particularly problematic as many other health challenges are most pronounced in rural areas, which compounds the issues.

Another key characteristic and challenge of the Kenyan health system is the **inequality** of care and access to care both between rural and urban areas as well as between the wealthy upper classes and impoverished masses. Rural health facilities often suffer from severe shortages of qualified health workers with appropriate skills. There is very little incentive for these workers to work in rural facilities when they can receive a superior standard of living, better equipped work environments, higher pay and more opportunities in urban centres (either in the public or private sector) in Kenya or overseas (Berman et al, 1995). According to 2008 figures, there were 728 medical doctors (MD) working in the Kenyan health system, with 477 employed in the public sector (MoPHS, 2008). There is also a significant difference in the standard of care between private for-profit health provision and state healthcare. Even within

state provided care, the difference between national level hospitals as opposed to less central district facilities is stark.

Inefficiency is also an issue demonstrated by long waiting times at healthcare facilities, bad inventory management for medicines, a convoluted ministerial structure and rife corruption (as a potential cause and effect of many of the challenges). After the tumultuous 2007 elections in Kenya, the Ministry of Health split into two separate institutions: the Ministry of Medical Services (MoMS) and the Ministry of Public Health and Sanitation. While this allowed for a clearer delineation of duties, it added additional strain on the health system by creating overlaps in planning and implementation that required the maintenance and operation costs of two separate institutions instead of one (Turin, 2010). The MoH returned to one central body in 2013. **Corruption** has a significant negative impact on the efficiency, quality and equity of healthcare services. It tends to decrease the quantity and increase the cost of care for both the provider and patient. This slowly undermines the healthcare system and corrodes the nation's overall level of wellness.

The **supply chain issues** within the health sector further undermine the level of care that can be provided. Barnes et al (2010) identify three key supply-specific challenges. The first is the large number of suppliers in the market, which leads to significant fragmentation among the different levels and drives down both the price and quality as competition intensifies. Secondly, there are “large quantities of substandard and counterfeit drugs that circulate in Kenya and the government has limited capacity to monitor and enforce quality standards” (Barnes et al, 2010: xvii). Lastly, the inefficient use of public resources as a result of the “duplication of efforts across the public, private, and not-for-profit supply chains” creates parallel systems that circumvent the public supply chain (ibid). This contributes to further inefficiency and regulation difficulties.

The **financial sustainability** of many health services is also precarious, especially among NGO and FBO providers who try to find the best balance of care and cost, often at the expense of financial independence. Fees are regularly waived for patients and costs of care and medicine kept low. While this allows quality care to be accessible for many who would otherwise struggle to afford it, it also lacks sustainability and is vulnerable to the varying resources of donors. In the NGO sector as a whole, lack of financial viability and reliance on donor funding is often the limiting factor that prevents facilities from offering a broader service spectrum, or offering services to more people (Turin, 2010).

There are also substantial challenges with the **information systems** needed to promote good health care. High quality health information is important for health sector planning, management, monitoring and evaluation (Luoma et al, 2010). A health information system (HIS) should include routine service data; census and vital statistics; surveys; surveillance; other population and facility based statistics and research; management statistics; and information and communication technologies (Luoma et al, 2010). Kenya's HIS is however "not sufficiently responsive or effective as it is constrained by inadequate governance structures and implementation of policy and framework documents; shortages of skilled professionals at all levels of the health system; and fragmented, vertical strengthening interventions" (Luoma et al, 2010: xxi). This affects the level of quality decision making that can be undertaken and undermines the smooth running of the sector.

Other challenges include the lack of coordination between the public and private sectors, lack of comprehensive approach to reform implementation in many areas, no single regulatory authority for health training institutions, inadequate platforms for procurement, financial and information management to health services decentralisation, over-reliance on external support for key health interventions and vulnerability to disasters and health related emergencies due to weak health systems and underdeveloped infrastructure (Barnes et al, 2010; WHO, 2009).

Opportunities in the Kenyan Health Sector

While some of the challenges above involve broad regulatory failures and socio-economic constraints, many can be addressed through the use of innovative models and coordinated approaches. Opportunities exist in the following key areas for innovations and interventions in financing and delivery mechanisms that can improve access to, availability and quality of health services (Dimovska et al, 2009):

- 1) Service delivery mechanisms to improve quality of and access to healthcare services
- 2) Risk-pooling mechanisms to improve access to health services and strengthen financial protection, innovative funding models, savings systems and insurance plans
- 3) Government and provider self-regulation mechanisms to improve quality by setting and enforcing standards
- 4) Public-private coordination to increase the collaborative efforts to meet healthcare needs

- 5) Incentive structure adaption to improve existing incentives to attract and retain a qualified workforce
- 6) Provider purchasing and contracting mechanisms to promote quality and availability of health services
- 7) Supply chain mechanisms to enable rapid scale-up, consistent quality, and improved access
- 8) Promote the innovative use of information and communication technology to expand access to care through tele-medicine solutions and electronic medical records and databases
- 9) Create models that target the demand side of health systems by educating patients to seek out the most beneficial health services through social marketing and conditional cash transfer programs

Although innovation in any one of these individual areas is unable to transform the Kenyan health system alone, it can provide an initial avenue towards long term health sector reforms. This is especially true if they are tackled in a coordinated manner by both the public and private sector. Table 4 below, taken from Dimovska et al's (2009: 4) report on innovative pro-poor financing and delivery models, displays a collection of key goals, the benefits derived from making progress on them and examples of models for achieving the goals.

Table 4. Innovative models to make health markets more effective and equitable

Goal	Potential benefits	Examples of models
Reduce fragmentation of providers	<ul style="list-style-type: none"> • Increase transparency, reduce informality, and create visibility and legality • Make it easier and less costly to regulate (reduce both cost and potential principal-agent problems) • Reduce transaction costs/information costs • Increase oversight 	<ul style="list-style-type: none"> • Franchises • Provider networks • Integrated models (pharmacy or clinic chains) • Professional associations
Change provider incentives and increase monitoring	<ul style="list-style-type: none"> • Align provider incentives with patient need for quality, affordability, and access • Sharpen the focus on quality by making patient volumes and payments contingent on meeting standards • Strengthen the ethics and self-accountability of the private sector (foster ethical behavior, create standards) 	<ul style="list-style-type: none"> • Network (HMO) models • Accreditation or licensing through professional association or other independent entities • Franchises • Pay-for-performance mechanisms • Any public or private demand-side financing mechanism (insurance, vouchers), when coupled with purchasing mechanisms designed to improve quality
Provide subsidies for target populations and high-impact interventions	<ul style="list-style-type: none"> • Increase access to higher quality care for the poor, create incentives for private providers to serve the poor • Increase use of high-impact effective interventions 	<ul style="list-style-type: none"> • Insurance • Vouchers
Educate patients to demand the most beneficial services and reduce asymmetries of information	<ul style="list-style-type: none"> • Increase demand for effective interventions, which may in turn increase supply • Reduce asymmetries of information 	<ul style="list-style-type: none"> • Social marketing • Rural cooperatives • Conditional cash transfer programs • Trusted knowledge brokers (citizen report cards, citizen complaint lines, consumer associations)
Use technologies that provide access and improve quality	<ul style="list-style-type: none"> • Increase efficiency • Improve quality and consistency 	<ul style="list-style-type: none"> • Telemedicine • Call centers • Kiosks • Electronic medical records

Opportunities for Social Enterprises in the Kenyan Health Sector

The current gaps in the healthcare system in Kenya highlight the need for new, innovative approaches to be formulated in order to address the pervasive problems that exist. Many of the challenges and opportunities discussed above are well positioned to be effectively addressed by the hybrid model adopted by social entrepreneurs. Through innovation and careful planning, the models mix the efficiency and sustainability of the private sector with the socially orientated goals of the public and not-for-profit sectors. The majority of SEs in the health sector in Kenya are likely to benefit from focussing on initiatives that 1) improve access and delivery models; 2) increase quality of care in existing delivery systems; 3) find ways to reduce the cost of care through innovative saving models and insurance plans to reduce out of pocket expenses by risk-pooling; 4) improve supply chain mechanism to ensure access to quality medicines; 5) create efficient scale up of operations and 6) find ways to bring better care to poorer areas to decrease the substantial inequality in care that currently exists in the Kenyan health system.

While there are a large number of health-based social enterprises operating in Kenya as shown in Section 4 below, there is very little literature which speaks directly to the role of social entrepreneurship in the health sector in general in Kenya. Sood, Burger, Yoong and Spreng (2012) note that there is limited systematic analysis of private health providers' experience of engagement with the public sector and that the level of engagement is often insubstantial. They propose that "improving engagement will likely help governments with limited resources to better take advantage of the private sector capacity to meet access and equity objectives and to accelerate the achievement of the MDGs".

2.5 Social Enterprises in the Kenyan Health Sector

This section provides an overview of existing health sector innovations in Kenya and then focuses on two particular examples as case studies to look at how social enterprises in the sector can address some of the challenges discussed above in practice.

2.5.1 An Overview of Existing Health Sector Innovations in Kenya

Social entrepreneurship is growing in Kenya and innovation in the health sector shows evidence of this growth. Table 5 below shows a list of for-profit health innovation programmes in Kenya with details on the programme activities, the parent organisation, geographical scope of work, year of launch and stage of enterprise, sources of funding, target population by location and income as well as the health focus. Table 6 shows a list of not-for-profit health innovation programmes in Kenya that have revenue as a primary source of funding and Table 7 shows not-for-profit enterprises that have revenue as a source of funding, but not a primary one. While these lists are not exhaustive, they serve to provide an indication of the nature of scope of social enterprises currently operating in the health sector in Kenya, categorised by their model for financial sustainability.

Table 5. For-profit health innovation programmes in Kenya

Program Name	Program Activities	Parent Organization	Also operates outside of Kenya?	Year	Stage (as of 2013)	Primary Source of Funding	Additional Sources of Funding	Health Focus	Geography
Access Afya	ORGANIZING DELIVERY - Health services chain; ENHANCING PROCESSES - Information communication technology		No	2012	Startup or pilot	Revenue (out of pocket payments)		Primary care	Urban
Afya Card	FINANCING CARE - Micro/community health insurance	AAR Healthcare	No	2003	No longer active	Donor	Revenue	Emergency care, Primary care, Secondary/tertiary care	Peri-urban, Urban
Afya Milele Halisi	FINANCING CARE - Micro/community health insurance; ENHANCING PROCESSES - Information communication technology	Eagle Africa Insurance Brokers	No		Existing or expanding (post-pilot)	Revenue (membership/subscription fees)		Maternal, newborn and child health, HIV/AIDS, Noncommunicable disease(s), Secondary/tertiary care	Rural, Peri-urban, Urban
CFC Life	FINANCING CARE - Micro/community health insurance		No	1970 and Before	Existing or expanding (post-pilot)			Other/not applicable	Rural, Peri-urban, Urban
Changamka Microhealth Limited	FINANCING CARE - Health savings, Vouchers; ENHANCING PROCESSES - Information communication technology		No	2008	Existing or expanding (post-pilot)	Revenue (membership/subscription fees)	Investor capital	Maternal, newborn and child health, Primary care	Rural, Peri-urban, Urban
CIC M-BIMA	FINANCING CARE - Micro/community health insurance; ENHANCING PROCESSES - Information communication technology	Co-operative Insurance Company of Kenya	No	2010	Existing or expanding (post-pilot)	Investor capital		Other/not applicable	Rural, Peri-urban, Urban
CIC - Micro health insurance for vendors	FINANCING CARE - Micro/community health insurance	Co-operative Insurance Company of Kenya	No	2008	Startup or pilot			Secondary/tertiary care	Rural, Peri-urban, Urban
Daktari 1525 Program	ENHANCING PROCESSES - Information communication technology	Call-a-Doc	No	2012	Existing or expanding (post-pilot)	Revenue (membership fees & OOP payments)	Revenue	Primary care	Rural, Peri-urban, Urban
Equity Bank	FINANCING CARE - Micro/community health insurance		No		Existing or expanding (post-pilot)	Revenue (membership/subscription fees)		Primary care, Secondary/tertiary care	Rural, Peri-urban, Urban
Faulu	FINANCING CARE - Micro/community health insurance; ENHANCING PROCESSES - Information communication technology	Pioneer Assurance	No	2010	Existing or expanding (post-pilot)	Revenue (membership/subscription fees)		Primary care, Secondary/tertiary care	Rural, Peri-urban, Urban
Mobile Diagnostic Services (MODISE)	ENHANCING PROCESSES - Information communication technology, Laboratory testing/diagnostics, Products/equipment		Yes		Existing or expanding (post-pilot)	Donor		Other/not applicable	Rural, Peri-urban, Urban
Penda Health	ORGANIZING DELIVERY - Health services chain; FINANCING CARE - Micro/community health insurance; ENHANCING PROCESSES - Information communication technology, Mobile clinic		No	2012	Startup or pilot	Revenue (out of pocket payments)	Donor	Maternal, newborn and child health, Family planning and reproductive health, Primary care	Peri-urban
Sproxil	ORGANIZING DELIVERY - Health services chain; CHANGING BEHAVIOR - Consumer education, Social marketing; ENHANCING PROCESSES - Information communication technology, Supply chain enhancements		Yes	2008	Existing or expanding (post-pilot)	Revenue		Pharmacy services	Rural, Peri-urban, Urban
Viva Afya (formerly Carego Livewell)	ORGANIZING DELIVERY - Health services chain; CHANGING BEHAVIOR - Consumer education; ENHANCING PROCESSES - Information communication technology, Innovative operational processes	Viva Healthcare Group	No	2008	Existing or expanding (post-pilot)	Revenue (out of pocket payments)	Donor; Government	Primary care	Peri-urban

Source: Data from the Centre for Health Market Innovations

Table 6. Not-for-profit health innovation programmes, revenue as a primary source of funding

Program Name	Program Activities	Parent Organization	Also operates outside of Kenya?	Year	Primary Source of Funding	Additional Sources of Funding	Health Focus	Geography	Target Demographic	Target Income
AMUA	ORGANIZING DELIVERY - Franchise; ENHANCING PROCESSES - Information communication technology, Mobile clinic	Marie Stopes International (MSI), Kenya; Government of Kenya	No	2004	Revenue (out of pocket payments)	Donor	Maternal, newborn & child health, Family planning & reproductive health, HIV/AIDS, Tuberculosis, Malaria	Rural, Peri-urban	Young adults (13-24), Men, Women	Bottom 20%, Lower-middle income (20-40%), Middle-income (40-60%)
Bima ya Jamii Project	FINANCING CARE - Micro/community health insurance; CHANGING BEHAVIOR - Consumer education	Cooperative Insurance Company (CIC) of Kenya; National Health Insurance Fund (NHIF)	No	2008	Revenue (membership/subscription fees)	Donor; Revenue	Primary care, Secondary/tertiary care	Rural, Peri-urban, Urban	Informal sector workers, General population	Bottom 20%, Lower-middle income (20-40%), Middle-income (40-60%)
Community Health Promotion Kenya (CHPK)	CHANGING BEHAVIOR - Consumer education, Provider training	Community Health Promotion Kenya (CHPK); North-Coast Medical Training, Coast Provincial Hospital, Ministry of Health	No	2009	Revenue	Government	Maternal, newborn and child health, HIV/AIDS, Malaria and other vector borne diseases		General population	Bottom 20% to Middle-income (40-60%)
Hope for African Children Initiative (HACI)	CHANGING BEHAVIOR - Consumer education, Provider training	CARE	Yes	2001	Revenue (out of pocket payments)		HIV/AIDS, Nutrition	Rural, Peri-urban, Urban	Children under five, Children five or older, Young adults (13-24)	All
Jamii Bora Trust	FINANCING CARE - Micro/community health insurance		No	2001	Revenue (membership/subscription fees)		Primary care, Secondary/tertiary care	Rural, Peri-urban, Urban	General population	Bottom 20%
K-MET Post Abortion Care Network	ORGANIZING DELIVERY - Franchise; CHANGING BEHAVIOR - Provider training	Kisumu Medical and Education Trust	No	1996	Revenue (out of pocket payments)	Donor; Revenue	Family planning and reproductive health	Rural, Peri-urban, Urban	General population	Bottom 20% to Middle-income (40-60%)
Mothers Club at the Kendu Bay Sub-district Hospital	CHANGING BEHAVIOR - Consumer education		No	2010	Revenue (membership/subscription fees)		Maternal, newborn and child health	Rural	Women	All
National Social Health Insurance Fund	FINANCING CARE - Government health insurance		No	2012	Revenue (membership/subscription fees)	Government	Primary care, Secondary/tertiary care	Rural, Peri-urban, Urban	General population	All
T.E.A.C.H	ORGANIZING DELIVERY - Health services network	Health Solutions	No	2011	Revenue (membership/subscription fees)	In-kind contributions	HIV/AIDS, Mental health	Rural, Peri-urban, Urban	General population	All
VisionSpring	ORGANIZING DELIVERY - Franchise; sub-subsidization; CHANGING BEHAVIOR - Consumer education, Provider training, Social marketing; ENHANCING PROCESSES - Products/equipment	FINANCING CARE - Cross-education, Provider training, Social marketing; ENHANCING PROCESSES - Products/equipment	Yes	2001	Revenue (out of pocket payments, other)	Donor; Investor capital	Eye care	Rural, Peri-urban, Urban	General population	Bottom 20%

Source: Data from the Centre for Health Market Innovations

Table 7. Not-for-profit health innovation programmes in Kenya, revenue as an additional source of funding

Program Name	Program Activities	Parent Organization	Also operates outside of Kenya?	Year	Health Focus	Geography	Target Demographic	Target Income
Child and Family Wellness (CFW) Shops	ORGANIZING DELIVERY - Franchise; CHANGING BEHAVIOR - Provider training; ENHANCING PROCESSES - Supply chain enhancements	HealthStore Foundation ; One Family Health	Yes	2000	Family planning and reproductive health, Malaria and other vector borne diseases, Nutrition	Rural, Peri-urban, Urban	General population	Bottom 20%
Gold Star Network Kenya (GSN)	ORGANIZING DELIVERY - Franchise	Family Health International	No	2006	Family planning and reproductive health, HIV/AIDS, Tuberculosis	Rural, Peri-urban, Urban	Formal sector workers	Higher middle-income (60-80%)
Jaipur Foot	CHANGING BEHAVIOR - Provider training; ENHANCING PROCESSES - Mobile clinic, Products/equipment	Bhagwan Mahaveer Viklang Sahayata Samiti (BMVSS)	Yes	1975	Rehabilitative care	Rural, Peri-urban, Urban	General population	Lower-middle income (20-40%), Middle-income (40-60%)
MicroEnsure	FINANCING CARE - Micro/community health insurance; REGULATING PERFORMANCE - Monitoring standards; ENHANCING PROCESSES - Information communication technology	Telenor Group; yuMobile	Yes	2001	Maternal, newborn and child health, Malaria and other vector borne diseases, Emergency care, Primary care	Rural, Peri-urban, Urban	General population	Bottom 20%
Nakuru Eye Unit Development Program	FINANCING CARE - Cross-subsidization		No	2004	Eye care	Rural, Peri-urban	General population	Bottom 20% to Middle-income (40-60%)
Private Nurse Midwives Networks in Kenya	ORGANIZING DELIVERY - Professional association; REGULATING PERFORMANCE - Monitoring standards; CHANGING BEHAVIOR - Provider training	Extending Service Delivery	No	2001	Maternal, newborn and child health, Family planning and reproductive health, Primary care	Rural, Peri-urban	Women	Bottom 20% to Middle-income (40-60%)
Riders for Health	CHANGING BEHAVIOR - Provider training; ENHANCING PROCESSES - Supply chain enhancements		Yes	1996	Other/not applicable	Rural, Peri-urban	General population	Bottom 20% to Higher middle-income (60-80%)
Safe Water and AIDS Project (SWAP)	CHANGING BEHAVIOR - Consumer education; ENHANCING PROCESSES - Innovative operational processes		No	2006	Maternal, newborn and child health, HIV/AIDS, Malaria and other vector borne diseases	Rural, Peri-urban, Urban	Children under five, Children five or older, Young adults (13-24), Men, Women	Bottom 20% to Higher middle-income (60-80%)

Source : Data from the Centre for Health Market Innovations

2.5.2 Case Study of a Health Sector Social Enterprise in Kenya

A case study of health based social enterprise in Kenya, which aims to be financially sustainable through revenue generation, is presented below. *Access Afya* is a social enterprise in its pilot phase. It aims to improve the healthcare delivery system in Kenya by creating a chain of ultra-mini-clinics that provide standardized outpatient services targeting the extreme poor. It offers high-quality, affordable, primary healthcare through its chain of health clinics using innovative technology to manage inventory, contact patients and maintain electronic medical records.

Access Afya - Health Kiosks for Kenyan Slums



Access Afya is a social enterprise that focusses on improving healthcare options for low-income Kenyans by using the latest health technology to deliver high quality, efficient care through a standardised ultra mini-clinic model (Access Afya, 2013). Operating in the context of the Kenyan healthcare system, where health care for many Kenyans is inconvenient, expensive and of low or inconsistent quality, Access Afya aims to improve health care for the extreme poor. Access Afya was co-founded in 2012 by Melissa Menke and Duncan Goldie-Scot who saw an opportunity for creating an enterprise that addressed some of the sector's challenges by 1) improving access to, 2) increasing quality of and 3) reduce costs for health care (Access Afya, 2013).

For a low-income Kenyan who gets sick, the process of seeking treatment typically involves either spending a substantial amount of time and transit money to go to a public facility, thereafter facing long waiting times for treatment or self-diagnosing and purchasing medication from an unregulated chemist. These are rarely staffed by trained professional with tests for accurate diagnoses. Where charitable programmes exist, their reach does not extend sufficiently to cover the millions living in extreme poverty or they have precarious funding arrangements involving significant subsidisation by donors. Access Afya highlights five key challenges of

the existing Kenyan healthcare system that they seek to address. They argue that for the ultra-poor, the current system is (Access Afya, 2013):

- 1) ***Inconvenient:*** Patients often take multiple modes of transport and spend a lot of time in line and moving between different facilities just to get simple ailments checked out. This wastes time, money, and keeps people out of work and school.
- 2) ***Expensive:*** Private providers are prohibitively expensive for the majority of Kenyans, and insurance markets are underdeveloped meaning most health expenses are paid out of pocket.
- 3) ***Subject to Weak Supply Chains:*** Counterfeit and stolen drugs have penetrated the Kenyan market. Many local chemists purchase medications from unreliable suppliers, and lack the capital to properly stock their stores. The Pharmacy and Poisons Board found that almost 30% of the drugs in Kenya were counterfeit.
- 4) ***Unpleasant:*** Stories of expired medication and people catching diseases from waiting rooms scare many people away from their surrounding providers. The lack of a clean, friendly place to get care puts many patients off following the prescribed avenues for accessing care in the public system.
- 5) ***Inconsistent:*** Roving nurses, program-specific monitoring, and one-day drives fill some gaps in the system, but leave patients without a comprehensive care provider.

Access Afya is a social enterprise setting up a network of “health kiosks”, or community care points offering basic healthcare services in low-income Kenyan neighborhoods. Each health kiosk is staffed by a nurse clinical officer, and a community health worker (Access Afya, 2013). The foundation of the model is to offer consultations, information, on-site diagnostics, and authentic medication through a network of high-tech health centres. The model makes it possible for patients to seek care early by bringing health workers and supplies directly to low-income communities. It also employs existing community health workers to help manage the clinic, which helps provide local knowledge and makes it more accessible to the community (Access Afya, 2013). Finally, these mini-clinics link into the public health care system by referring the more complicated cases to the next level of care.

It essentially creates an extra level of high quality, accessible care in hard to reach communities. The pilot clinic treated over 200 patients between December 2012 and March 2013 (Centre for Health Market Innovation, 2013). During this time Access Afya received approximately \$1400 in revenues (Parrish, 2013).

In order to make Access Afya sustainable whilst effectively addressing some of the healthcare shortfalls, the model incorporates technology and operation processes in the following innovative ways (Access Afya, 2013; Centre for Health Market Innovations, 2013; Start Some Good, 2013):

- 1) ***Efficient design:*** kiosks are designed to take up the minimum space required so that they can fit into the spaces available in the slums instead of being located outside and causing patients to commute.
- 2) ***Paperless Clinics:*** clinics manage patient records, stock, SMS communication and clinical protocols through electronic systems. All data is stored and accessible via this electronic system so that health workers know each patient's treatment history during a consultation. It also increases efficiency and decreases running costs.
- 3) ***Digital Protocols:*** digital versions of protocols are available to health care workers at the clinic, which provides additional support during treatment and helps standardise care to make the clinic model scalable.
- 4) ***Mobile technology:*** As mobile phones are widely used in Kenya, even in low-income settings, it offers an opportunity for innovation. Access Afya capitalises on this using texting to strengthen customer relationships with follow-ups, improve operational efficiency with appointment reminders and data collection, and create better health outcomes by sending targeted messages to groups, such as nutrition tips for new mothers.
- 5) ***Reliable Supplies:*** Using the electronic system to manage inventory levels and streamline stocking procedures allows the clinic to maintain adequate levels of medical equipment and drugs.
- 6) ***Low Cost and creative fee structures:*** The price point of an average consultation, diagnosis, and treatment at Access Afya is around US\$4.00. This is about a fifth of the cost at the nearest private clinic. While customers have the option of paying per use, innovation health financing options include

‘packages’ of care and clinic memberships. This incentivises patients to seek medical care as cost becomes less of a barrier and the payment plans better match low-income patient cash flows.

- 7) ***Scalable model:*** The model is designed to be replicated in other low-income areas around Nairobi through the use of technology. A mini-clinic takes four weeks and \$5000 to construct, furnish and stock.
- 8) ***Use of existing networks:*** Access Afya builds on the existing community social infrastructure, through community health workers, savings groups, and schools, to promote products and screen potential clients.

The operating environment has enabled Access Afya’s pilot to launch successfully as the business model fits into MoH strategy and goals, including increasing primary care, services for expectant mothers, public-private partnerships, and health technologies. Partnership with the public sector, from licensing to reporting to receiving free supplies, makes the model more feasible and scalable. Additionally, Nairobi’s position as an emerging technology centre as well as the high mobile penetration increases scope for further technological innovation and partnerships with private sector organisations in this space. Other associations that helped co-founder and CEO, Melissa Menke launch Access Afya include her academic training at New York University’s Wagner School as well as her time with the William James Foundation Mentoring Programme for social entrepreneurs (Parrish, 2013).

While the first clinic has been well received, gaining recognition from patients and social innovation groups, a major challenge going forward will be to maintain financial viability whilst scaling up and building extra clinics beyond the pilot. Access Afya will still have to navigate the challenges of finding suitable sites, attracting qualified health professionals and creating awareness around the subsequent clinics, which would involve changing attitudes regarding health care expectations and processes within low-income areas. Access Afya has started addressing this by building strong local support networks and developing a solid knowledge of the target market through the electronic database of patients’ demographics, symptoms and treatments.

3. RESEARCH METHODOLOGY

3.1 Research Approach and Strategy

This is an exploratory study, involving an open and flexible research approach aimed at ensuring comprehension and the generation of new insights into a little understood context. Currently, general understanding of the broader environment of the social enterprises is still sparse, and more so within an African health sector context. This investigation intends to reveal deeper understanding about the experience of social enterprises and the entrepreneurs and societal needs that drive them. In order to achieve this, primary qualitative data collection and grounded theory analytical methods were used. Small sample research based on experience surveys with experts, in-depth interviews, focus group interviews and case study analysis was undertaken.

The method of data analysis selected for this study was the classical grounded theory approach, as initially proposed by Glaser and Strauss (1967) and developed by Glaser (1978, 1992, 1998, 2001, 2003, 2005, 2011). This approach differs (despite some core similarities) from other qualitative methods as well as from the constructivist grounded theory method adapted and proposed by Charmaz (2003, 2006) and the Straussian grounded theory method (Strauss & Corbin, 1990, 1998). The constructivist grounded theory asserts that reality is constructed by individuals as they assign meaning to the world around them (Breckenridge, Jones, Elliot & Nicol, 2012). Charmaz (2003: 250) proposes a version of grounded theory that “assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and the viewed, and aims toward an interpretive understanding of subjects’ meaning”. As this study aims to identify and conceptually explain the patterns of behaviour in which people engage and the theory that emerges around a core concern, rather than simply tell participants’ stories, it aligns itself more closely with the classical grounded theory approach.

Further, classical grounded theory was selected as the research approach for this study as its systematic procedures (such as simultaneous collection and analysis of data and the constant comparative logic and theory that emerges from data) provide it with rigor that is not accounted for in other qualitative approaches (El Hussein, Hirst, Salyers & Osuji, 2014). It is also one of the few qualitative methods that prioritises the generation of theory (El Hussein et al, 2014; Charmaz, 2014). It specifically puts emphasis on generating theories that “(1) enable an explanation of behaviour, (2) are useful in advancing a theory, (3) are applicable in practice, (4) provide a perspective on behaviour, (5) guide and provide a style for research on particular

areas of behaviour, and (6) provide clear enough categories and hypotheses that crucial ones can be verified in present and future research” (Goulding, 2002: 43). This makes it an appealing choice as it creates a valuable and verifiable end product. While this study is unlikely to yield definitive answers, it should point to theoretical propositions that have emerged from the collected data. Each of these form the basis of a hypothesis that can be investigated in future research studies.

The research site for this study was Nairobi, Kenya. As a thriving capital of social and technological innovation geared towards solving social and environmental problems, it served as a suitable geographic focus and urban base. The city also represents an increasingly regional hub for people from all over the world to travel and engage around the development problems and possibilities of the African continent. The majority of social enterprises in health care either operate in and around Nairobi, or have an office there. This made it ideal for accessing social enterprises, government bodies and support institutions. Interviews were conducted primarily within the urban centre of Nairobi, but included surrounding areas where time, availability of stakeholder and resources permitted. Site visits were also made to gain exposure to the social enterprise operating in its context.

The field trip took place over a two and a half week period in November 2013. There was a team of researchers conducting interviews and collecting data. Three were from the University of Cape Town’s Graduate School of Business, two from the Overseas Development Institute in London (during the first week) and a few staff and students from KCA University in Nairobi who assisted during the trip. When possible, two researchers would form a team to be at a semi-structured interview at the same time. This reduced the likelihood of missing important lines of questioning and allowed a lead interviewer to concentrate on interacting with the interviewee(s) whilst the partner took notes and kept track of what still needed to be covered.

Two to three interviews were conducted each day by each team, depending on travelling distances and availability of participants. This helped cover a wider range of stakeholders than would be possible with a single researcher or smaller team. Every evening the research team convened to share experiences, thoughts and plan for the coming days. Notes and reflections were captured on an ongoing basis throughout the field trip. This helped document emerging themes and guide the upcoming interviews. It also served to expose any potential researcher biases or perceptions that may influence that collection process.

3.2 Data Collection, Frequency and Choice of Data

Data collection followed the case study methodology (the in-depth systematic exploration of a phenomenon via the collection and analysis of multiple forms of data) developed by scholars such as Yin (2003) and Eisenhardt (1989). In this study, data was primarily collected through semi-structured, in-depth interviews with selected representatives of various organizations and institutions. This method encouraged the respondent to speak freely on the topics being questioned, providing opportunity for rich, detailed information to be collected. The open form of gathering information is structured by the specificity of the questions so as to make sure that the information collected is directed and relevant to the initial objectives of the study. The general frameworks of questions and interview protocols were developed prior to the field trip and can be found in Appendix 2. However, as an exploratory study, some of these questions were adjusted throughout the course of the trip. This was in response to an evolving understanding of the context and issues under research as the field trip progressed. Such evolution is an integral part of the grounded theory process (Elliot & Lazenbatt, 2005). Some interviews also deviated from the designed structure as information that came up naturally led onto other related topics of interest to the study. It was important to be sensitive to this in order to get the most out of a respondent's experience and knowledge.

In addition to manual notes made at the time, interviews were digitally recorded with the consent of the respondent. The subject had the right to suspend, discontinue, or withdraw from the interview at any time he or she felt necessary. Only designated individuals involved in the research process had access to the data in order to ensure security of information. Subjects' identities have been coded and kept confidential so as to protect their identity and affiliations, and will only be disclosed with the permission of the subject.

To supplement interviews, additional data collection methods such as site observations, collection of documentation, open-structured interviews, and focus groups were also employed when appropriate (Yin, 2003). Site observations were made when visiting the physical location of the social enterprise or organisation's base of operations; a central office or a branch of activities such as a hospital or clinic. On these occasions, notes were made on the interactions and activities observed. Throughout the field trip, personal observations of both formal and informal experiences were collected as an additional source of information. Documentation data forms include pamphlets, magazines, newspaper articles, strategy documents, brochures, and other forms of written, tangible material that communicate information about the actor or

organization (Kolb, 2012). Open-ended interviews were employed as a means to use broad questions to encourage free dialogue. This helped capture nuances and ideas that may not have come up within the structure of a more directed set of questions. It was particularly useful during unplanned encounters, for example with community members, patients and other members of staff not formally included in the semi-structured interviews. Although at the start the intention was to include focus groups, the constraints of finding a time to convene a large group of stakeholders together at one point proved prohibitive during the two week field study.

3.3 Sampling

Grounded theory data collection is guided by theoretical sampling, which means that data collection is based on theoretically relevant constructs and is informed by previous data collection and analysis (Glaser, 1978). This allows the initial selection of research subjects to maximise the discovery of different dimensions and conditions related to the phenomenon under study as possible (Strauss & Corbin, 1998). The initial sample is selected in line with the research situation. The population of interest in this study consists of the individuals, organizations, and institutions that form the social entrepreneurial environment in Kenya. The sample of social entrepreneurs and stakeholders within the broader ecosystem consists of the following sub-categories of respondents: Social enterprises, representatives of policy-making bodies, regulatory agencies, local and national government agencies, local and international support organisations including academic institutions, incubators and development networks, service providers and beneficiaries.

The sample was collected first via the probability sampling technique of stratified purposeful sampling, by which the broader social enterprise environment was divided into sub-strata as identified above (Ellsberg & Heise, 2005: 106). The aim was to include a comparable representation of each sub-category of respondents in the study. Purposeful sampling means that each sub-category of respondents was selected for their match to the research topic and their anticipated ability to generate relevant data. Organisations and institutions were targeted for an interview according to their presumed alignment and interest in the field of social entrepreneurship. This alignment had been laid out in a mapping exercise conducted by the team in the weeks preceding the field trip. In order to increase the credibility of this sample, the strategy of maximum variation was applied. This allows the different dimensions of the issues under study to be identified and common patterns that cut across variations to be observed

(Ellsberg & Heise, 2005: 106). In this case, different types of social enterprises were targeted as well as support organisation, service providers and government institutions.

Within each strata, the non-probability sampling methods of snowballing sampling and convenient sampling were then applied to identify possible subjects and interview those who were most accessible and available (FHI, 2005). Several subjects targeted for participation were from high profile organisations with demanding positions. As such, only those willing and able to make time for an interview could be included. Fortunately, very few participants that were targeted were unable to accommodate the researchers. New respondents were discovered and contacted during the field trip after existing participants suggested other individuals and organisations who would fit the area of research.

With grounded theory, theoretical sampling usually extends beyond the process of putting together a diverse, relevant initial sample. It is also applied to the iterative process of sourcing further samples as the research project progresses (Engward, 2013). Theoretical sampling is defined as “the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges’ (Glaser & Strauss 1967: 45). Therefore, as categories emerge from the data during analysis, it informs the next stage of sampling. In this way, “process of data collection is controlled by the emerging theory”, which adds conceptual depth to the study (Glaser, 1978: 36). Thus the sample is emergent, as is the theory and method generally (Glaser & Strauss, 1967). For the study, this was done to some extent within the single field trip. However, due to time and resource constraints, successive rounds of field trips and data collection were not possible. This limited the amount of theoretical sampling that took place and falls short of full grounded theory research where multiple iterations of analysis and data collection take place, often extending over many years.

Table 8 shows the support organisations that were interviewed during the course of the field trip (those specific to the health sector and those general to social entrepreneurship development). Table 9 shows the social enterprises from the health sector that were interviewed, capturing the date started and a brief description of what they do. Table A1 in Appendix 3 provides a more in depth look at the health SEs interviewed. It indicates the applicable SE definition that fits each, the model being used, the year each was started, the area of focus, sources of finance and stage of growth.

Table 8. Support organisations interviewed

<i>Acumen Fund</i>	Acumen is a non-profit that raises charitable donations to invest in companies, leaders, and ideas. Acumen financially supports high social impact entrepreneurs via the provision of ‘patient capital’ – finance that is flexible, has long-term horizons, is primarily driven by social returns over shareholder returns, and takes into account ventures of high risk.
<i>ANDE</i>	ANDE is a global network of organisations that propel entrepreneurship in emerging markets. ANDE members provide critical financial, educational, and business support services to small and growing business based on the conviction that these businesses will create jobs, stimulate long-term economic growth, and produce environmental and social benefits.
<i>Ashoka</i>	Ashoka is the largest network of social entrepreneurs worldwide. Founded in 1980, Ashoka has provided start-up financing, professional support services, and connection to a global network across business and social sectors, and a platform for people dedicated to changing the world.
<i>British Council</i>	The British Council is the UK’s international organisation for educational and cultural relations. British Council Kenya creates platforms for co-creational activities between digital media entrepreneurs and creative entrepreneurs to initiate entrepreneurial activity of social consequence.
<i>CIC Insurance</i>	CIC Insurance is a prominent insurance provider in Kenya, and the largest provider of micro-insurance. It provides insurance products to cooperatives. It serves as the largest cooperative insurance company in Africa. Cooperatives represent 75% of its shareholders.
<i>DFID Kenya</i>	Department for International Development – UK’s aid department office in Kenya.
<i>EASEN</i>	East Africa Social Entrepreneurs Network – EASEN is a membership organisation committed to the development of the social enterprise sector in East Africa.
<i>Enablis</i>	Enablis is a non-profit organisation that empowers local entrepreneurs and supports them in the growth of their businesses in conjunction with government, private sector and civil society. Enablis provides initial funding for low-interest loans, matched by a partnering bank, as well as financial strategy and guidance.
<i>iHUB</i>	iHUB, Nairobi’s Innovation Hub for the technology community, is an open space for the technologists, investors, tech companies and hackers. iHUB has a focus on young entrepreneurs, web and mobile phone programmers, designers, and researchers. It is part open-community workspace, part vector for investors and VCs, and part incubator.
<i>KSIX</i>	Kenya Social Investment Exchange – seeks to promote social investment in Kenya. It is positioned to provide funding for group-owned SEs, currently as grant-centred funding, and in time as equity-based funding.
<i>LIWA</i>	Linking Industry with Academia – LIWA’s mission is to facilitate industry-academia linkages, and thereby facilitate institutionalised and sustainable relationships between stakeholders.

<i>Ministry of Health</i>	National ministry responsible for health in Kenya.
<i>Open Capital Advisors</i>	Open Capital Advisors is a financial services and strategy consulting firm that supports high-impact business, investors, and innovative solutions throughout East Africa. Open Capital Advisors enables sustainable businesses to plan their growth and raise capital, and helps funders to allocate capital efficiently.
<i>RISE</i>	Regional Institute for Social Enterprise (RISE)'s mission it to work with the local community to identify, prioritise, and implement sustainable social and economic issues by providing consultancy to promote community-based and owned enterprises.
<i>Strathmore Business School</i>	Strathmore University is a private university based in Nairobi. Strathmore Business School supports incubation of emerging enterprises to further develop its business model and product offering. Strathmore has just established a Centre on Health Innovation and Policy to support the efforts of health innovators across the country.
<i>Techno-Serve</i>	TechnoServe is a non-profit organisation that develops business solutions to poverty by linking people to information, capital and markets.
<i>UNDP</i>	United Nations Development Programme partners with people at all levels of society to help build nations that can withstand crisis and can drive and sustain the kind of growth that improves the quality of life for everyone. UNDP Kenya has a steering committee that supports and incubates SEs.
<i>USIU</i>	The United States International University Kenya has a Global Social Sustainability Entrepreneurship Program which provides a concentration on social entrepreneurship as part of USIU's MBA programme. Students' main deliverable is to design an SE, which is incubated at the university on the completion of their degree.
<i>Vision 2030</i>	Kenya Vision 2030 is the national long-term development blueprint that aims to transform Kenya into a newly industrialising, middle-income country.

Source: modified from Griffin-EL, Darko, Chater & Mburu, 2014: 9-10

Table 9. Health SEs interviewed

<i>Access Afya</i>	2012	Primary care in low-income areas provided primarily through micro-clinics.
<i>Alive & Kicking</i>	2004	Profits from manufactured footballs used to fund health education through sports, especially focussing on HIV/AIDS.
<i>Melchizedek Hospital</i>	2001	Uses cross-subsidisation to provide comprehensive hospital-based health care.

<i>Metropolitan Hospital</i>	1994	Comprehensive hospital-based health care, both inpatient and outpatient using innovative systems technology to increase efficiency and decrease costs to target the middle market.
<i>Sproxil</i>	2008	Verification of authentic drugs through mobile technology free to the user to combat drug counterfeits in the market.
<i>Upperhill Eye & Laser Centre</i>	1998	Provision of specialist eye care in areas where such services are otherwise unavailable through the use of cross subsidisation from its private clinic.
<i>Viva Afya</i>	2008	Provides high-quality, comprehensive affordable primary care in low-income areas through the use of a hub and spoke model.
<i>Zana Africa</i>	2008	Invests in women and girls to break the cycle of poverty across generations by making affordable sanitary pads, delivering health education, and informing policy.

Source: modified from Griffin-EL, Darko, Chater & Mburu, 2014: 7

3.4 Data Analysis Methods

As previously noted, this study follows the classical grounded theory approach to data analysis, borrowing from Strauss and Corbin's extension on stages of coding. Grounded theory is a relatively new approach originally defined as "the discovery of theory from data" (Glaser & Strauss, 1967: XX). It uses inductive logic where the researcher does not start with a hypothesis or theory and then prove or disprove it, but rather the researcher first starts by collecting data in the research setting, concurrently analyses it, and then generates a theory that is grounded in the data (El Hussein et al, 2014; Strauss & Corbin, 1990). According to Glaser and Strauss (1967: 31), the theory is "either a well-codified set of propositions or a running text of theoretical discussion, using conceptual categories and their properties". These propositions are reached after an extensive process of thematic coding and constant comparison.

Constant comparison is a key feature of grounded theory. It involves contrasting data against itself, against evolving original data, and against existing theoretical and conceptual claims (Boychuk & Morgan, 2004). This constant comparison necessitates making ongoing notes (memos) and examining the data many times from many different perspectives (Amsteus, 2014: 13). Memo writing is another central part of the grounded theory approach. It consists of the researcher making personal notes about what feel is happening in the data, reflections on

philosophical research positions, issues, analytical decision making, and developing theory (amongst many other topics). As Stocker and Close (2013: 1) note, memos are “a useful tool for exploring and challenging our underlying processes and assumptions embodied within our codes in order to construct theory and raise theoretical sensitivity, and can be helpful to capture and illustrate the development of theory as data collection and analysis progresses”. Constant comparison and memo writing occurred all throughout the data collection and coding process.

As this suggests, with a grounded qualitative study, the analysis starts as soon as data has begun to be collected (Engward, 2013). Initial ideas of how the data fits together are loosely formed and noted. These adapt throughout the collection of data and inform, but not bias, the formal analysis of that data. This process occurred during the interviews and site visits, as well as during the team’s evening feedback sessions on the fieldtrip. After the collection of data was completed, transcribed digital recordings were created. This, along with the other primary data collected, was analysed through the use of thematic coding methods.

While the overall approach of analysis is that of classical grounded theory, the coding process is more similar to the grounded theory approach extended by Strauss and Corbin (1990). This was selected as it encourages a more structured and detailed approach to coding than the other methods allow (Thai, Chong & Agrawal, 2012). Thematic coding refers to the methodical examination of qualitative data, where the data is broken down into smaller bits of meaningful information – either by words, phrases, or whole paragraphs (Egan, 2002). Those are then compared and contrasted in order to cluster them by similarities and differences. The categories that are found get coded (renamed) for the broader idea or theme that they convey. This allows patterns and frequencies of themes to emerge. Once similar instances appear over and over again, there can be empirical confidence that a category is saturated (Glaser & Strauss, 2012).

Coding follows three stages. The first is open coding where initial concepts are uncovered and categories of information are formed. This is “the process of breaking down, examining, comparing, conceptualising, and categorising data” (Strauss & Corbin, 1990: 61). The second is axial coding. During this stage the data and categories identified during open coding are assembled in a way that 1) identifies a central phenomenon, 2) explores causal conditions and relationships between categories, 3) identifies the context and intervening conditions, and 4) looks at consequences and influences of relationships (Thai et al, 2012). The third is selective coding. This is the last step in the coding process and involves the integration of the categories in the axial coding phase to develop a theory. Ultimately, this third stage is “the process of selecting the core category, systematically relating it to other categories,

validating those relationships, and filling in categories that need further refinement or development (Strauss & Corbin, 1990: 116). A core category, concern or condition is identified and a set of related propositions are then presented. These form the underlying structure of the generated theory. Because it is intimately linked to the data, grounded theory is designed to last, even if it needs to be modified or reformulated over time (Glaser & Strauss, 2012). While its focus is on the generation of theory, grounded theory should provide models of conceptualisation with “clear enough categories and hypotheses so that crucial ones can be verified in present and future research” (Glaser & Strauss, 2012: 3).

In the context of this research project, thematic coding was applied to identify common themes concerning how social entrepreneurs identify and articulate their objectives, execute their operational strategy, and perceive the challenges which hinder their work. The study also analysed data collected from other stakeholders in the ecosystem to add perspective on the environment within which social enterprises find themselves.

3.5 Research Reliability and Validity

Research reliability is concerned with whether the same results would be obtained repeating the study in a different set of circumstances. It indicates the credibility of the procedures used and the results achieved. Validity addresses the how well the research tools measure the phenomenon under question (Roberts, Priest & Traynor, 2006). It indicates whether what the study claims it is measuring, is actually what it is measuring. Typically these terms have a better fit with quantitative, rather than qualitative studies. This is especially true for grounded theory, where context and the evolution of the research process are considered so fundamental. However, it is still important to assess the underlying trustworthiness of the study, even if different criteria are used (Roberts et al, 2006).

Guba (1981) developed criteria of trustworthiness which parallel the traditional quantitative criteria of internal validity, external validity, reliability, and objectivity. Specifically, four main indicators of trustworthiness that should be established in a grounded theory study have been proposed: credibility (the qualitative equivalent to internal validity), transferability (the qualitative counterpart to external validity), dependability (the qualitative counterpart to reliability), and confirmability (the qualitative equivalent to objectivity – i.e. would another researcher acquire the same results).

To enhance the trustworthiness of this study, the following techniques were used: triangulation, collective debriefing, reflexivity, ensuring sufficient variation in participant selection, respondent validation, data saturation, peer review of the data and findings, and an audit trail (research journal, memos and carefully documented methodology decisions). Triangulation involved the use of multiple data sources (outlined earlier) and researchers to corroborate findings and reduce the risk of error or bias (Thai et al, 2012). Before the field trip, participant selection and stakeholder mapping was done to identify a ‘typical’ range of respondents to be targeted for interviews and to identify the level of alignment each had with the study. During the field trip and in the months following it, collective debriefing occurred between the whole research team. This helped everyone to deconstruct the day’s activities, verbalise initial thoughts and findings, discuss any difficulties and collectively determine the best approach for the subsequent interviews. This reduction of subjectivity and bias risk through group interactions was one aspect used to increase credibility, but it was also important to use field journals to capture ideas, connections, methodological notes, etc. on an individual basis. Known as reflexivity, this method helps establish an awareness of one’s own thought patterns, limitations and potential biases (Thai et al, 2012).

After the field trip an initial data analysis took place. From this a preliminary report was circulated among the participants and disseminated at a follow up workshop in Nairobi. The workshop gathered together key stakeholders in the social entrepreneurship, health and agriculture spaces. This allowed respondents and participants to offer feedback or point out an errors or misrepresentation, which could then be dealt with in further stages of analysis. Although most often described as a test of validity (Lincoln and Guba 1985), respondent validation also provides the researcher with the opportunity to reflect and amend their interpretations where appropriate (Bitsch, 2006: 44). Peer reviews were regularly conducted on preliminary reports and analysis amongst the research team, which further helped refine ideas and remove susceptibility to bias.

To combat the dangers of researcher bias so inherent in qualitative studies and improve objectivity, interviews were recorded with the consent of the participants. These were professionally transcribed and paired with the additional handwritten notes of key points, attitudes and non-verbal communication made during and after each interview. This combination of transcriptions and personal observational notes helped prevent the selective collection and recording of data and minimise interpretation based on primarily on personal perspectives (Bitsch, 2006).

3.6 Limitations

In grounded theory, you do not begin with a theory and then attempt to “prove” or “disprove” it (Strauss & Corbin, 1990). Instead, you begin with an area of study and allow what is relevant within that area to emerge. This has the potential to bring out some novel findings and can generate new insights into the area under study. Some scholars argue that the generated theory is considered to be fallible, dependent on context and never fully complete (Engward, 2012). This would make it hard to extrapolate the findings to other situations without verification. Other scholars, following Glaser, hold that grounded theory has the ability to reveal high level concepts and theories that are not specific to a particular participant or setting and can be generalised across contexts (Glaser, 2002; El Hussein et al, 2014). Either way, it is important to recognise that while a theory has been generated, it has not been tested in any further work. This would be a logical progression for further study.

As a qualitative study, there is an inherent danger of researcher bias. Such bias can be avoided through the use of 'bracketing', whereby researchers attempt to suspend their experience, judgement and beliefs (Bitsch, 2006). Although every attempt has been made to minimise any researcher bias, it can never be fully eliminated. While this does not invalidate the study itself, it can potentially undermine its reliability. In a grounded theory approach, another way to overcome this is to note down any perceptions and biases and include them in the study as more data (Glaser, 1998). This externalises the bias and allows it to be treated with the same analytical lens as the rest of the data.

Some of the most substantial limitations of this study arise as a result of using Kenya as the research context. Due to the length of the field trip, there was limited time to interview many participants. Not all of the targeted participants were available during the trip and the time constraints meant that not all could be included. The main goal in any grounded theory study is to gather enough data in successive rounds until theoretical saturation has occurred. The exact numbers for when this occurs differs between studies. However, it is commonly accepted that a sample size between 12 and 30 is appropriate (Creswell, 1998; Guest, Bunce, & Johnson, 2006). In total, 19 regulatory and support organisations and 8 health specific social enterprises were interviewed for this study. Although this sample size meets suggested number for meaningful research, there is still room for the study to be expanded.

Working from Cape Town also made it problematic to engage in meaningful follow up or allow for repeat interviews after returning from Nairobi, which would not have been the case

if the distance had not been so great. Due to these limitations, the iterative process of collecting data, then analysing, the returning to the field to collect more data (and repeat) was not possible. The fact that only one iteration of data collection was done is another limitation of this study. Full grounded theory research would encourage multiple iterations of collection that are informed through theoretical sampling. Although all other aspects of the grounded theory approach were followed, in this respect, the study falls short.

4. RESEARCH FINDINGS, ANALYSIS AND DISCUSSION

4. Overview

This chapter discusses the findings from the analysis of the field work data. The primary research question (*What drives and affects innovation among social enterprises in Kenya's health sector?*) will be dealt with in section 4.1. Here innovation is defined as the development of processes, programmes or products that can enable improved care delivery in an inclusive, effective and affordable way whilst simultaneously encouraging change in the routines, resources and values within the health system.

A theoretical framework is proposed and then expounded. This addresses the primary research question as well as exploring the nature of the following sub-questions:

- Who are the key actors and how do they shape the environment for social entrepreneurship within the health sector in Kenya?
- What are the key challenges and barriers to innovation through social entrepreneurship in the health sector in Kenya and how have social enterprises dealt with these?
- What are the key needs and opportunities that spur innovation within the health sector in Kenya and what are the models that have been created to meet these needs and exploit these opportunities?

Section 4.2 considers other themes that have emerged from the data and affect the ecosystem for SEs in Kenya. Specifically it deals with 1) the challenges surrounding the concept of and identification with social entrepreneurship; 2) developing a Kenyan framework for SEs; 3) the dynamics of donor culture and the influence of the 'West'; and 4) the issues around measuring impact as an SE.

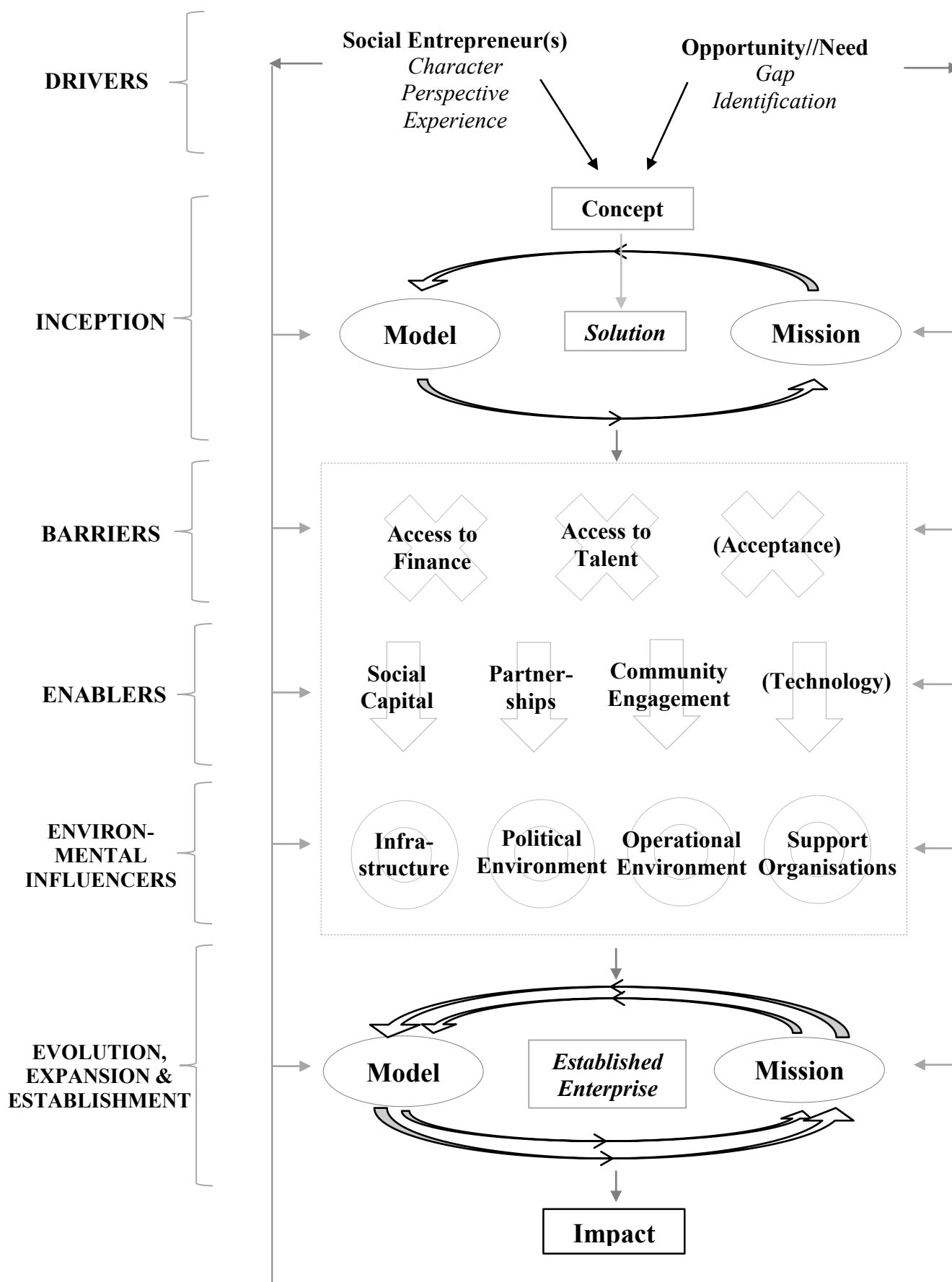
Finally, section 4.3 concludes by offering a summary of theoretical propositions that capture the key findings of the study. Ultimately, this chapter presents a theory around the core theme of *establishing a social enterprise that has impact in a developing country's health sector*.

4.1 What drives innovation among SEs in Kenya's health sector?

This section formalises a framework based on the findings from the grounded theory process. Each category from the framework is then discussed in more detail, with specific relationships between each captured below and in the set of propositions in section 4.3.

4.1.1 A Theoretical Framework

Figure 7. What drives innovation among social enterprises in Kenya's health sector?



4.1.2 Drivers

Throughout this study, two main drivers of social innovation in Kenya's health sector have emerged. The first is(are) the social entrepreneur(s) – the person or group of people who recognise an unmet need and are willing to step forward to address it. The second are the needs themselves – the gaps in healthcare provision which double up as opportunities for the improvement and expansion of the sector. These two drivers interact together to promote innovation. Without the unmet needs and gaps in the provision of healthcare, there would be little innovation to improve the situation. Without an individual or group of people with a vision, creativity and persistence, many of these gaps would continue to be unaddressed.

This section deals with each of these drivers in turn, looking at how the character, experience and perspective of the social entrepreneur as well as the needs in the sector combine to produce innovative models that offer a positive impact on Kenya's health sector. Considering Figure 7 above, these two drivers also serve to influence the entire chain of events and frame the whole process.

The social entrepreneur

The social entrepreneur's character, experience and perspective are what tends to make them unique and influences their success as innovators. A number of common threads emerged when exploring the role of the social entrepreneurs in this study. Firstly, their perspective is different. They see the gaps in the system and recognise the potential for positive change. They are not satisfied with the status quo and are willing to challenge it by actively seeking a solution to improve the situation and raise the level of awareness around the issue in question. They are creative and think outside the box to break with convention and charter a new course forward. They measure success in terms of the progress towards their mission, which is focussed on social impact, not monetary gain or power.

This is supported by research that examines the motivations and aspirations of young entrepreneurs in Uganda (Langevang, Namatovu & Dawa, 2012). Langevang et al (2012) explore the motivations behind entrepreneurial activity, from both a financial and social perspective. They emphasise the influence of the entrepreneurs' socio-economic environment, social networks, family relationships and life experiences. They note that many entrepreneurs are not only affected by the social context, but also seek to influence it. Despite the focus of

their research being on the broad range of entrepreneurs, not social entrepreneurs in particular, the findings are very similar.

The social entrepreneurs' character is also important. They are passionate and believe in what they are doing. The SEs' vision is central to all their efforts. A SE respondent noted the importance of passion:

"The one thing I realised, if you have a passion for something, a lot of barriers just drop out of the way. We never had to bribe anyone."

The social entrepreneurs genuinely care about those they are serving and are not simply exploiting a gap in the market for their own advancement. They are willing to sacrifice and invest of themselves to achieve the vision. They are bold and persistent and can deal with the cycles of disappointments and challenges. They persevere through the barriers, unwilling to give up when meeting resistance. They are ready to take risks and to do things other will not. One of the SE respondents expressed this as having everyone think he was crazy:

"Then, when we were starting off, most, a good number of people classified me as borderline mad.... Safe enough to be public, but crazy nonetheless, because that place we chose to be was considered to be inhabited by people who couldn't afford private health care."

They also use their past experiences to shape their current and future actions. They learn and develop as they go, using everything as an opportunity to grow and improve. They are persistent and will tenaciously follow their vision. When asked what advice he would give to aspiring social entrepreneurs, one of the respondents said,

"One, to follow their dreams and secondly to be able to put in long hours, long hours at work and to look at every encounter as an opportunity."

Although there is usually only one or two individuals at the beginning who drive the process, over time they draw in others who share their conviction and together they seek to realise their mission. In the early stages the social entrepreneur is vital to the success of the enterprise. If they exited the enterprise, it would most likely fall apart. In later stages however, the SE has enough momentum and other people on board that it is no longer solely reliant on the single driving individual. The driver becomes a team, rather than a lone entrepreneur.

Needs and opportunities

The needs and opportunities found within healthcare in Kenya are the other significant drivers of innovation in the sector and often form the backbone of the social enterprise's mission and model. The following five themes in this section represent the most prominent issues addressed. The majority of these attempt to reduce the inequality of healthcare that is evident in Kenya both between rural and urban areas as well as between the wealthy upper classes and impoverished masses.

Placing this within the existing literature, all of the SEs within this study were innovating in the non-State health sector. However, there is a growing body of literature calling for innovative improvements within the public provision of health services (Albury, 2004; Leadbeater, 2004; Bessant & Maher, 2009). While this research does not specifically address innovation within the public sector, a lot of the findings are transferable. The demands for cost cutting from the funding side mix with demands for better non-price aspects of healthcare from the users. This results in a complex situation needing solutions driven by innovation in the state provision of healthcare services (Bessant & Maher, 2009). The path that this takes in a developing country setting would be an interesting area for further study.

Accessibility (based on geographical proximity and income)

Many Kenyans have to travel long distances to access health care and once there face long waiting times at the facilities before receiving care. Although no one is excluded from receiving healthcare, the time and cost associated with accessing care makes it prohibitive for many. This accessibility challenge is based almost exclusively on geographical location linked to wealth. The low-income population tends to have the least access to healthcare facilities.

Quality

Not only should patients have access to health care facilities but these facilities should be equipped to provide the necessary care or be able to refer upwards for more complex cases. In practice, many facilities in rural and low-income areas are often understaffed, underequipped and have limited medicines. This further disincentivises the utilisation of health resources. Patients who have travelled far and incurred the costs only to have substandard care and limited

medication options are less likely to return in the future. This exacerbates the country's already poor health indicators.

Assessing the quality of a healthcare facility or service is a very multi-dimensional activity. While it can be difficult to quantify, a number of elements are typically included. Measures such as the number of appropriately qualified staff at a facility, the availability of medicines, the level of respect and dignity given to the patient, the standard of care, the length of time it takes to get seen and the cleanliness of the environment are important to consider. The primary challenge is how to maintain quality whilst keeping costs low. Many models are structured around finding a solution to this.

Affordability

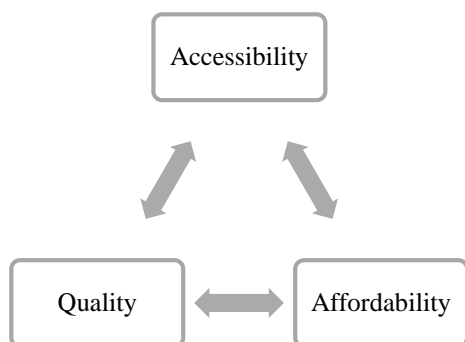
Generally there is an option between low cost with lower quality and high cost with higher quality healthcare. This leaves a largely untapped "middle market". Although some non-state providers target it, it still presents a significant gap in health provision.

In terms of health insurance in Kenya, there are two broad types of formal insurance: the National Health Insurance Fund (NHIF) and private health insurance. Approximately 88% of Kenyans with insurance are covered by the NHIF. There is currently very little widespread coverage by private insurers and that which exists is largely limited to those in formal sector employment in urban areas (Berman et al, 1995). A report published in 2010 put the number of privately insured Kenyans at about 600 000, roughly 2% of the total population (Barnes et al, 2010: 29).

As employment figures increase, this growing middle class represents a substantial opportunity to expand healthcare services. One of the social enterprises interviewed who targets this middle market noted:

"Because of a growing middle class, there is scope for expansion. Now we don't have enough. We don't have enough health care facilities, especially those that would be able to give, to do that middle of the road where they are pursuing a medium, a low margin, let me call it a low margin, high volume model. ...Because as people get work here, they want better health care and for many Kenyans they don't trust government services and they don't have any trust in government services, they are overcrowded, we've got to use private solutions."

The Access-Cost-Quality Trilemma



The ideal situation for a healthcare facility is to provide high **quality** care that is easily **accessible** and **affordable** to those who need it. The existing system however, tends to present a trade-off between these three such that only two can be achieved at the expense of the third. Healthcare in Kenya that is accessible and high-quality tends also to be high-cost and out of the reach of many citizens. Accessible care that is affordable tends to be lower-quality. The challenge that many social enterprises try to address is how to design a model that overcomes this trilemma and provides all three elements without compromise.

Product and model innovation

In addition to improving access, quality and affordability, another major opportunity (and need) for innovation in the health sector exists in the product development market. This ranges from insurance products to sanitary wear to medical devices and drugs, all offering an improvement in health, convenience and wellbeing for the end user. For example, one of the social enterprises interviewed offers a product to pharmaceutical companies to include on their drugs so that the consumer can text or phone through a code (for free) that is specific to the drug to instantly verify whether it is genuine or counterfeit. In a context where fake drugs are prolific (acting as placebos at best or dangerous substances at worst), not only does this innovation safeguard the consumer, it also starts reducing the market for counterfeits as more drug manufacturers include this on their products.

Another social enterprise focusses on adapting the way sanitary pads get designed, manufactured and packaged to make them more affordable to the low-income segment of the population. This improves women's health indicators and better meets the consumption patterns of its target group by being packaged in units of one and two pads per pack. It also reduces school absenteeism by providing an accessible sanitary product. A number of social enterprises have also utilised the high mobile phone penetration rate and M-Pesa (mobile money) platform to create health insurance packages that meet the needs and budgets of a range of consumers.

Model innovation also plays an important part in enabling health needs and opportunities to be met and utilised. Micro-clinics, cross-subsidisation and low-margin/high-volume models are three of the major broad classes of models used to address gaps in the

provision of quality, affordable and accessible healthcare. Micro-clinics, using a variety of methods to maintain internal sustainability, extend the reach of primary care further into communities so that individuals' proximity to a health facility is increased. Cross-subsidisation uses the 'those who can pay subsidise those who cannot' principal. One of the social enterprises works in an upper market area and uses the profits to run specialist clinics in rural areas so that the cost of treatment is substantially subsidised. This maintains the financial sustainability of the model whilst allowing healthcare to be provided to people who previously did not have access to it.

Reframing the 'Bottom of the Pyramid' market

An interesting finding whilst talking to actors in this space was the emergence of new way of thinking about the so-called 'bottom of the pyramid' (BoP) market. This reframing views the BoP as a large market of discerning and loyal customers who can distinguish between products and assess what gives good value for money rather than categorising them as indiscriminate consumers willing to purchase anything that is cheap. This is in contrast to a lot of literature which portrays the BoP market as a testing ground for new ideas, an area for business growth and potential for new revenue sources (Linna, 2012). As a group that uses limited resources to maximum benefit in order to survive, they are astute at assessing what gives value for money and spread information via word of mouth.

"They [those in the BoP market] have great loyalty. Once they know that there is a benefit and it is affordable. Because for them that affordability is really in question. Once they find something that is affordable that works, it spreads like wildfire."

- A health social enterprise respondent

Many social enterprises stressed the importance of involving this segment of the market in design and implementation processes. Instead of viewing this segment as needing charity, they recognise that there is disposable income and a willingness to invest in valuable outcomes. SEs see opportunity for sustainable enterprises that meet the needs of this group in a dignified way. A low margin, high volume model is usually adopted in these cases.

Table 10 summarises these driving needs (opportunities for innovation) and looks at the SEs that have designed models to address the gap.

Table 10. Needs and opportunities being addressed by Social Enterprises

	Niche	Example of SE addressing this niche
Access-Affordability-Quality Trilemma	<i>Micro-clinics and primary care</i>	Viva Afya and Access Afya both use micro-clinic models to extend the reach beyond that of the smallest public primary care clinic. This leads to affordable, accessible primary healthcare in poor areas where previously there was limited access and low quality care. These models are made sustainable largely through the use of a ‘hub and spoke’ model where one larger, more equipped ‘hub’ supports and provides more specialised services to a number of ‘spoke’ clinics as well as through the efficient use of supply chains and internal efficiency.
	<i>Affordable secondary and tertiary care in hospitals</i>	Metropolitan Hospital and Melchizedek Hospital both offer comprehensive hospital-based healthcare, both in-patient and out-patient, that is affordable and accessible to low and middle income groups. Metropolitan Hospital uses a fully integrated, self-designed software system to increase efficiency and reduce costs. Melchizedek on the other hand uses a model of cross-subsidisation to lower cost and extend its services to a wider range of clients.
	<i>Affordable specialist care</i>	UHEAL (Upper Hill Eye and Laser Clinic) works in an upper market area and uses the profits to run specialist eye clinics in rural areas so that the cost of treatment is substantially subsidised. This maintains the financial sustainability of the model whilst allowing healthcare to be provided to people who previously did not have access to it.
Product and Model Innovation	<i>Access to safe, quality drugs</i>	Sproxil offers a product to pharmaceutical companies to include on their drugs so that the consumer can text or phone through a code (for free) that is specific to the drug to instantly verify whether it is genuine or counterfeit. In a context where fake drugs are prolific (acting as placebos at best or dangerous substances at worst), not only does this innovation safeguard the consumer, it also starts reducing the market for counterfeits as more drug manufacturers include this on their products.
	<i>Sanitary product innovation</i>	Zana Africa focusses on adapting the way sanitary pads get designed, manufactured and packaged to make them more affordable to the low-income segment of the population. Not only does this improve women’s health indicators and better meet the consumption patterns of its target group by being packaged in units of one and two pads per pack, it also reduces school absenteeism by providing an accessible sanitary product.
	<i>Health insurance products</i>	Mobisure and Changamka Health Ltd both utilise the high mobile phone penetration rate and M-Pesa (mobile money) platform to create health insurance packages that meet the needs and budgets of a range of consumers. This extends the availability of health insurance to a wider range of the population and reduces the out of pocket costs of health care for the consumer.
	<i>Model innovation</i>	As demonstrated by the examples above, model innovation also plays an important part in enabling health needs and opportunities to be met and utilised. Micro-clinics, cross-subsidisation and low-margin/high-volume models are three of the major broad classes of models used to address gaps in the provision of quality, affordable and accessible healthcare.

4.1.3 Inception

The inception is the first stage of the SE model. The social entrepreneur recognises a need and forms an idea. This solution takes shape in two forms, 1) The mission, which captures what the social entrepreneur is wanting to achieve and 2) The model, which is the design that determines how this mission will be realised. Both are key features of the SE and constantly influence and shape each other. Especially in the early stages, there is a careful design of the model as well as continual development as the mission is clarified and the model evolves to best fulfil the mission.

The mission

The mission of the SE originates from the identification of a gap in the provision of healthcare services. The social entrepreneur articulates a clear vision of what they want to focus on and achieve. The mission can evolve or expand over time but usually stays within the parameters of the original goal. A clear vision is important for getting other people on board and effectively designing a model. The mission must be based on the actual needs rather than the needs as perceived by the social entrepreneur. Katzenstein and Chrispin (2011: 90) have similar findings and point out that:

“Focusing attention on health issues ensures that the health needs of a target population are the central focus of the intervention rather than the needs of those driving the intervention. Health initiatives in developing countries are frequently about the needs of the donor organizations, technology manufacturers, or political entities. By focusing first on the health issue, the social mission becomes explicit and the goal of the intervention is framed to emphasize the positive impact on society”.

Intrinsic to the mission of an SE is the manner in which it meets the need and innovates a solution. One of the SEs interviewed captured this as follows:

“...to listen to what their needs are and how they are trying to meet them now and what they inspired to. I mean that’s your job to try to innovate ways to meet people’s not just their needs but to supply them with the product that will give them dignity and will inspire them.”

The model

The creation of the model is a process that is intrinsically linked to the mission and is fuelled by an understanding of the reality facing the SEs’ beneficiaries. Community engagement, past

experience and knowledge gained from ‘on the ground’ understanding all shape the model. This is because the priority of the model should be to meet the mission in the best way possible given the various presenting opportunities and constraints. The model needs to be carefully designed in order to find a sustainable way to meet the mission. Because of the imperative to maintain low margins and offer low costs to consumers whilst still remaining financially viable, a great emphasis is placed on efficiency. Many SEs spoke about the importance of optimising care. By this they meant making the most of each resource by matching the need precisely. One of the hospital SEs made the point:

“For all practical purposes the health care system was using a sledge hammer to kill a mosquito. For example child immunisation, you’d find paediatricians doing child immunisation here. Because the market has a significant private sector. People can afford it, so they go straight to a paediatrician for a jab and that adds cost. It doesn’t add anything to quality... Then on staffing, in fact across the whole value chain, we simply found there were a lot of services that were being provided by overqualified people. That simply added cost, you know. If you go to some of the hospitals, you’ll find nurses making beds. Increases cost, it really doesn’t improve quality. So we call it optimal care.”

Even those SEs which are not reliant on revenue to be sustainable, still stressed the importance of being careful and intentional with their allocation of effort and resources. Not only is the model concerned with the affordable, quality provision of the good or service, but also about how best to get beneficiaries to access the good or service. Designing creative payment packages and accessible options for different beneficiaries to keep the SEs offering within their reach is important. Ultimately, although the actual structure of the model varies from SE to SE, but the process and motivation behind the design of the model is very similar.

4.1.4 Challenges

Whilst challenges often translate into opportunities for innovation and growth, they can also act as significant obstacles in the life cycle of a social enterprise. If not dealt with, these can become barriers that prevent the SE from moving forward. The three main barriers that were common across all SEs interviewed are 1) access to appropriately skilled human resources, 2) access to finance and 3) overcoming public scepticism to gain acceptance amongst other professionals and their target consumers. George, McGahan and Prabhu (2012), when

considering the drivers and constraints to innovation, also articulated these challenges. Additionally, they considered government regulation and lack of technological know-how as constraints, which are also emergent themes in this study but dealt with under different classifications. This section explores each of these three emergent challenges further.

Access to human resources

A major challenge in the health sector is the lack of adequately qualified professionals, especially (but not limited to) doctors. Those that are trained and qualified are difficult to attract largely due to the significant salary differentials between what a typical start-up social enterprise can offer in comparison to an established high-end private facility. Rural health facilities in particular suffer from severe shortages of qualified health workers as there is very little incentive for these workers to work in rural areas when they can receive a superior standard of living, better equipped work environments, higher pay and more opportunities in urban centres (either in the public or private sector) in Kenya or overseas.

The existing shortage is exacerbated by the flight of qualified healthcare professionals out of Kenya, mainly to developed nations where the remuneration and quality of life is better.

“My sister is a doctor, she is in the US, she would like to come back home, we have a lot of work to do here, so there are a lot of doctors all over the place that they are making more money out there, obviously getting more experience, but they need to come back and if Government is able to really support their move back and take a decision that Kenya is going to be the destination for the best medical treatment in Eastern Central Africa, and reward doctors accordingly, then they will probably, possibly come back and you can see a big difference.”

- Hospital CEO respondent

According to 2008 figures, there were only 728 medical doctors (MD) working in the Kenyan health system, with 477 employed in the public sector (MoPHS, 2008). There is also a trend for private healthcare consumers to go to other countries to receive what is perceived to be better care. As one of the SE interviewees noted:

“Our patient who travels from, who insist on going to South Africa to get treatment is a kind of problem because they say they have to go to, we have got cardiology here, but South Africa they have the best and so forth. So patients are flying to Jo’burg to one of the hospitals and guess who they will see there? A doctor who is a Kenyan.”

After obtaining the appropriately skilled healthcare professional and other support staff, the challenge lies in retaining them. While some SEs commented that a lot of their good staff got poached by other companies, a key theme in retaining staff is their buy-in to the mission. The social entrepreneur heading up one of the micro-clinic SEs interviewed discussed this:

“At first they are just looking for a job. Every health care [facility], they think that everybody’s doing the same thing. But we’ve retained them because they’ve bought into the mission. The ones that have been here the longest, I believe that’s not just because of my pay. Yeah, I try to be competitive, but I can’t pay top, top end salaries.”

The SEs interviewed for the study all placed importance on valuing and developing their staff. They care not only about meeting the needs of their target market but also those of their workers. Many prioritise a good working environment for their staff with additional training, viewing them as part of the team. This is a very different attitude to the typical private or public sector work environments. A couple also noted the importance of expanding their mission to include skills training for the wider Kenyan health professional work force. This was viewed as part of the vision to address shortcoming in the provision of quality healthcare to all those living in Kenya.

The challenge of accessing talent extends beyond attracting qualified healthcare professionals. Getting people who have good business skills that can support the functioning of the enterprise is also difficult. A common trend of supplementing business acumen by involving external professionals was observed. This source of free expertise would often come in short-term form, such as students from foreign prestigious universities, foreign professionals on volunteer or missions’ projects, and scholars or interns with short-term appointments.

Accessing finance for the ‘missing middle’

Starting up and running any enterprise requires funding but accessing these finances in Kenya can be difficult. Most social enterprises listed this as one of their major challenges. While there are many resources available, they often come with considerable restrictions and are limited to SEs at particular growth stages. The biggest gap exists for the medium sized SEs and those in an early stage. Many are too big or advanced to receive seed funding from grant organisations but too small to be attractive for other traditional investors. Foundational, public, and philanthropic funding in the form of grants also tends to be made available to non-profit social

enterprises over their for-profit counterparts. This makes it very difficult for SEs listed as companies to access the finances required for launching an enterprise very.

“We were talking about how much capital there is in health care and it’s true, on the one hand there’s so much capital chasing for good deals. There really is, but once you get into it and you start to engage with all of these people who have a capital, and who you are trying to get into business with, you find that they are as frustrated, because there’s requirements that they have where in terms of where their capital should go and the small businesses cannot meet those requirements.”

- A health SE respondent on accessing finance

Providing credit to a new small enterprise, especially one whose main priority may not be profit, is risky and therefore expensive. The majority of banks are either unwilling to lend or charge very high rates when they do. As most capital comes with high interest rates and restrictive requirements, it seriously undermines a young enterprise’s ability to succeed. Ngara (2011) also identifies a lack of risk capital in Africa as a leading challenge for entrepreneurship. Many SEs also had a problem coming up with adequate collateral. Those who had collateral (for example expensive medical equipment) were often turned away because it was not in the form traditionally accepted by the bank.

“Because if you go to a bank, they want collateral, they want history, you know, they want to know, they want you to have had an account with them, they will base their decision on only the cash flow in your statement and the collateral that you’ve got to give. Whether that idea is a fantastic idea, I don’t know, they really don’t have time for that.”

- A health SE respondent on accessing finance

Angel investors and other equity funders who are willing to take on the risk tend only to want to invest in social enterprises that are operating in a post-revenue, pre-profit stage. This leaves a significant gap in early stage funding. For those who can access it, it often comes with restrictions, conditionality, and strict timeframes for implementation and measuring impact that do not take into account the complex realities of a social enterprise’s operations. Additionally, as there have been few investment exists to date due to the infant nature of this field, it is still too early to assess the viability of this type of investment which further increases the perceived risks.

“If you look at all these other guys, they may invest in smaller projects, but for them it is rate of time and exit. You know, social enterprise, hmm... How do we make our money here? And then they want money quickly, they are not looking at ten years. They want four years, exiting, they have doubled their retirement, there’s viable plans and there’s IPO’s.”

- A health SE respondent on accessing finance

Often all it would take was one individual or organisation to step forward and give the SE a chance. This was a prevailing theme in accessing finance. Most banks turned the SE away until someone was willing to put themselves on the line to back the SE. This usually occurred when a financier bought into the vision of the enterprise. Aside from banks, the Acumen Fund in particular was mentioned as being willing to support social enterprises. They would take on more risk than other investors and provide funding based on an idea rather than waiting for an already functioning enterprise to exist. Further, they were willing to take on the foreign exchange risk and provide financing in the local currency to shield the enterprise from extra loan repayment expenses arising from currency fluctuations.

Although a number of support organisations mentioned the growing role of impact investment, none of the SEs interviewed had experience with it. As an innovation in finance where investment decisions are based upon the considerations of social and environmental impact as well as financial return, it is predicted to have a large part to play in financing SEs in the future. However, it is still relatively new in Kenya and many actors appear to be waiting to see its proven success before committing to it as an approach to investing.

Interestingly, there was resistance among SEs to engaging with corporations for funding and endorsement in their start-up phases. Several social enterprises, for example, mentioned that pursuing corporate social investment seemed to be ‘too much work for too little gain’. They argued that SEs eventually end up being exploited or working tirelessly for a corporate affiliation that yields little return to the advancement of their venture, and would make it increasingly dependent, restricting its growth and ability to scale. Similar reluctance was expressed by some on the merits and dangers of donor funding. This is explored further in Section 4.2.

Public attitudes and the importance of building trust and acceptance

Dealing with the different public attitudes encountered in a way that is constructive and reinforces the enterprises' work and mission is an important challenge to navigate. Many new ventures, especially those that challenge the status-quo, often face initial scepticism from the communities they work in as well as from their mainstream contemporaries. Two social entrepreneurs being interviewed summed it up:

“But then probably the biggest challenge to starting off was public scepticism. Getting past that. There was a real challenge.”

“One, acceptance. Because you know we were unknown completely. No one knew us. And so at the beginning there was a lot of suspicion and also because of past experiences, because there are very many quacks out there fleecing the patients and trying to get as much money also. ...Also acceptance by the government healthcare system. You know a lot of these hospitals now know us. Initially there was a lot of suspicion, there was a question of you know, nothing is for free, what are you guys after? You know, let's wait and see what their end game is. After a year or two people realise, hello, you know, there's nothing, they just want to help.”

This process of gaining acceptance and building trust, while very important, is timely and costly. The longer it takes for acceptance, the more costs the SE has to incur before generating revenue.

“Acceptance is always a challenge yet those earlier doctors like the will quickly see what it can do for them and their docket. The majority of the manufacturing industries will first of all want to watch it and understand it before they can come in and that period of watching and understanding the whole technology can take between a year and a year and a half but at the back end you have the costs that you are incurring.”

- A health SE respondent on acceptance

Although initial acceptance is a barrier, if it is overcome, it turns into an enabler and allows the SEs' work to have greater impact.

“Once it is proven, people want to come in and the way I see it is as we prove ourselves in each country that we go to, two years from now it is a solution that everybody will organize and then everybody will want to fund it.”

- A health SE respondent on acceptance

While getting beneficiaries and other professional actors to accept and trust the SE, an important spin off of this process is raising awareness. For example, a social enterprise whose mission is to reduce HIV incidence within a given community not only needs to be accepted for the work they do but also needs to increase public awareness around the issues involved to reinforce the progress towards achieving their mission. Engaging the different stakeholders throughout the various processes is a way to overcome this challenge but requires time, dedication and insight.

“Which was also one of the objectives of this thing in raising awareness to the government, to say look, you people think there is no problem. We will show you there is a problem. We will screen these patients and we will show you just how many need treatment. ...so it’s demonstrated to the government, the need, and the government has begun to invest in that space.”

- A health SE respondent on raising awareness

4.1.5 Enablers

In contrast to needs and opportunities that spur social innovation, enablers are the factors that create a conducive environment in which social enterprises can develop and operate and allow them to overcome the challenges encountered. Social capital, partnerships, community engagement and technology will be discussed as the key emerging enablers from this study.

Social capital

The use of social capital for the start-up and growth of social enterprises should not be understated. In a context where access to finance and human resources is a major challenge, social capital provides a means to overcome these obstacles. One of the social entrepreneurs spoken to used social capital through networks he had built up over his previous years of study and work to access financial capital and human resources for his start up.

“We had in those years, we had no money. We went to our lecturers and senior doctors and asked them to invest money. So my Chairman on board was my lecturer at school.”

This meant he could go ahead with his enterprise even when most banks and investors were unwilling to provide capital. Social capital is also useful when enterprises work with their beneficiaries. Building trust over time, for example, can provide a viable way to overcome

security concerns as members in the recipient communities start ‘backing’ the enterprise. Using social capital for networking opportunities, having someone vouch for you or introduce you to an important connection is also an extremely valuable enabler.

“You don’t actually need cash from somebody, what you need is for them to introduce you to a bank, that bank will not look at you alone, but when you’re escorted, or there’s a call from someone, or a guarantee, at times all it takes is somebody to see and believe in what this guy is doing, or a simple guarantee and they will look at it differently.”

- A social entrepreneur respondent on networking

Social capital as an enabling factor for entrepreneurs is validated by a number of studies (Aldrich & Zimmer 1986; Burt, 1992; Sorenson and Stuart, 2001; Egbert, 2004; Kristiansen 2004; Kotha and George, 2012). Although most existing literature speaks to the positive impact of social capital and networks, some scholars have highlighted its potential restrictive effects. In particular, Egbert (2009), considering the case of Tanzania, notes that while the entrepreneur can gain essential resources for the enterprise through social networks (e.g. information, financial capital, labour, tools), the accompanying social obligations and responsibilities may make those same networks act as a constraining factor for entrepreneurs. Khayesi and George (2011) had similar findings in Uganda. While this was not the experience of the social entrepreneurs interviewed, it is still a relevant, alternative point to be considered.

Partnerships

“You can’t do without partnership. We have support from the government we have support from the regulatory bodies, we have support from the media, we have support from our partners.”

- A health social enterprise respondent

Many social enterprises noted external partnerships, collaboration and support as an important enabler for successfully operating. These partnerships were between the social enterprises and various support organisations, university programmes, business plan competitions and government initiatives and ranged from capacity building, to special funding arrangements and provision of short-term expertise. Although this came up as a general emergent theme in the study, Meyskens and Carsrud (2011) did specific research into the role of partnerships on nascent social ventures and found that partnerships are more important for non-profit and hybrid

social ventures than for for-profit social ventures. Their findings also suggest that partnerships are more essential for social ventures operating in developing regions such as Africa, Asia and Latin America where institutional constraints are greater than in the United States or Canada (Meyskens & Carsrud, 2011: 61).

In the health sector where many social entrepreneurs have some form of medical background, their specialist business, financial and management know-how is often lacking. This makes these partnerships and collaborations even more important. For example, groups of students travelling on short-term projects from top international universities would go to Nairobi to spend time with the social enterprise. Their assistance ranged from model development to financial systems structuring and market research.

The data also reveals that several social enterprises engage with government in positive ways, including endorsement of activities, co-hosting of launching and distribution events and outsourcing training initiatives (Griffin-El, Darko, Chater & Mburu, 2014). For example, one of the SEs reported being contracted by the government to train other doctors in the use of specialist equipment for surgery. The data suggest that the work of SEs and government tend to be complimentary and they work towards similar goals in providing needed services for urban and rural populations – rather than in opposition or in competition to each other. This is particularly relevant in healthcare provision where there is still much ground to cover in order to raise standards and offer universal coverage.

With regards to alleviating the distrust communities have towards new enterprises, the positive engagement between social enterprises and government opens up the opportunity for government to provide endorsement or certification of the goods and services that social enterprises provide. This ‘stamp of public approval’ can distinguish them from the disingenuous organizations, and increase the trust with populations that have been mistreated by companies or initiatives before. An interesting point to note is that there seems to be very little collaboration between different SEs or SEs and social entrepreneurship networks.

Community Engagement and Leverage

“So again the aim was to identify the community and go deeper then. So from the work I’ve done in the rural areas, I realise how much trust was necessary, you know it’s not just about going out and doing a business and making money out of it, but that

the community needs to trust you and they need to know who you are and you need to communicate with them and they need to see you out there with them.”

- An SE respondent on community engagement

A predominant dimension of the innovation that drives social enterprises is the in-depth engagement with the members and households of the communities they serve. Owners of various SEs noted that as some economically poor and peripheral communities have experienced exploitation or mistreatment by organizations offering assistance in the past, they become distrustful of new products and services by unfamiliar organizations. Hence, a large part of their innovative work is building the necessary relationships and forging the trust with community members so as to cultivate a symbiotic engagement between social enterprise and customer. SEs have developed various tactics for this, such as identifying champions in the community to help carry out initiatives and mobilize others and leveraging existing community networks and relationships. One of the SEs interviewed used this as a dominant strategy for getting their products to beneficiaries in low-income communities:

“Pads are an intimate product so we basically trying to leverage community ties to facilitate access to pads from somebody you trust, somebody who is at your doorstep and someone who is also in your income group and is generally in income by selling our product that is staying within communities.”

Technology

An area in which Kenya is currently thriving is in the emergence of information and communications technology (ICT). The high penetration levels of mobile phones and the innovative use of mobile phones for financial transactions and collaboration (including Mpesa, iHub & mLab) has allowed for SEs to create new processes and ways of developing models and products to meet the needs of society. Linna (2012) also argues that technology, especially ICT, is one of the major enablers of economic growth and innovation in sub-Saharan Africa. Her research in Kenya shows that mobile technology is growing and influencing new business models as well as leading to an increasing number of tech incubators and hubs being formed. In the health sector technology's influence takes a number of forms including electronic medical records, SMS services to disseminate health information and remind patients of check-up dates and medicine schedules, verification of authentic drugs through mobile services, remote second opinions for complicated medical conditions in rural areas and integrating

information technology systems throughout hospitals in order to increase efficiency and minimise costs.

Although technology is a significant enabler of innovation, many SEs noted that it can still be expensive to develop and set up. It also often requires additional training for staff who have to use technology that may be unfamiliar to them. This additional time and expense needs to be weighed against the benefits of having a good ICT structure. Some support organisations also expressed concern that the perceived maturity of Kenya's ICT sector may be exaggerated and that more can be done to build good ICT infrastructure. Similarly, Van Rensburg, Veldman and Jenkins (2008) in their study on technology for development also commented that the evidence suggests that many ICT projects fail and that the hype around ICT in Sub-Saharan Africa is based on “woulds” and “coulds” instead of “has” and “does”. Katzensteing and Chrispin (2011) suggest that it is important for technology that it suit the level of development in the country as well as being appropriate for the specific site at which it is used.

4.1.6 Environmental Influencers

This section discusses the major environmental influencers that affect SEs. While neither inherently positive nor negative, each can be a barrier or enabler depending on the structure of the environment and its interaction with the SE. In a study on encouraging entrepreneurship in South Africa, a key conclusion was the importance of establishing a conducive environment for entrepreneurship and business activities (Centre for Development & Enterprise, 2004). The emerging themes from the research in Kenya suggests that the same holds true. Similarly, Katzenstein and Chrispin (2011), in their research on the opportunities and challenges faced by social entrepreneurs in Tanzania and Cameroon, also find the environment shaping the way SEs get things done in a developing country is distinct from that of a highly industrialised nation. They identified that learning how to navigate the cultural, organisational and political landscape is a key determinant of success for SEs in developing countries (Katzenstein & Chrispin, 2011: 87).

Infrastructure

Infrastructure, if established and effective, can create a conducive environment for SEs (or any enterprise for that matter) to operate in. The quality of the infrastructure impacts the access for clients to the social enterprise's services as well as the supply chain logistics of the enterprise

itself. Good transport routes, reliable power supply and functioning communication networks enable SEs to function effectively. If any of these systems are poor or inconsistent, it can be a substantial barrier for the SE. Although Kenya's infrastructure is improving and the government is placing a high priority on its development, many areas still suffer from poor infrastructure (Vision 2030, 2013: 19). This is especially in lower income areas where a lot of SEs operate.

"It took three months to get a line, one line. So we were attempting to run a hospital without a phone. No more water and no landline, we are using a public telephone booth, there's a market, a public market next to us. That was our phone for three months. Very, very disabling."

- SE respondent discussing infrastructure constraints

Political Environment

The political environment is determined by the existing policies and regulation, the degree of corruption and bureaucracy, the level of political uncertainty and the role the government plays. The general consensus among the SEs interviewed regarding the state of regulation in the health sector is that the lack of strict rulings allows a level of flexibility that encourages innovation rather than presenting any substantial obstacles. Additionally, the process of devolution being undertaken in Kenya at present offers a number of opportunities for public-private collaboration and partnerships. This can help foster engagement between different actors and increase efficiency by reducing overlaps and allowing each to focus on their strengths. However, Kenya's active political scene and the recent political changes have contributed to uncertainty not only in the SE space but also in the business and investment sectors. For instance, it was mentioned that coordinating efforts with local governments is often a challenge during the election period (Griffin-El et al, 2014). Although it is understandable that attention is shifted to the political scene during such times, this and other indirect political interference slows down on-going projects or the rolling out new projects.

Although public institutions are said to be bureaucratic, slow and sometimes rife with corruption, the general feeling was that in recent years, these aspects had improved. In fact, when compared to government institutions of other countries in the region, dealings with Kenyan government institutions were considered easier, faster and more transparent. Once stable, the devolution of power from the central government to the different county governments is expected to speed up processes further. This is because the responsibility of

public institutions will be broken down and therefore easier to manage, public institutions will be easier to access as they will have a presence in every county and accountability will be easier to monitor hence discouraging corruption.

All SEs felt that the Kenyan government has a direct role to play in improving the health sector as well as the viability of social enterprises within the sector. They spoke with approval about the positive actions the government was taking (both the MoH specifically and the GoK in general). They noted that the GoK is promoting skills training and placement experience for young workers, offering free drugs and medical services for eligible private providers to disburse, and promoting certain SEs as they become aware of what they are doing. On the other hand, they also expressed that the government could be doing more: increasing spending on the health sector, monitoring standards and protecting local business from fake imported merchandise, offering incentives for enterprises delivering socially desirable goods and services, exploring tax options for SEs and creating innovation hubs that promote the development of SEs. They should also continue to prioritise and invest in infrastructure developments and business process improvements (for example minimising the time it takes to get a license). In terms of promoting a conducive business environment, major advancements have already been witnessed:

“But, yes I have a very positive view what I’ve seen the government do is unbelievable because the mind shift is in our favour it’s actually promoting businesses. The mind shift is unbelievable the government is really trying hard to make sure that the business environment is suitable for both foreign and local businesses and also because the current leadership is made up with people who are also businessmen so they know from their own businesses so they make the environment conducive enough for private business.”

- SE respondent on business promotion

After speaking to a representative from the MoH, an interesting point was raised. They noted that the emphasis on healthcare could not be solely the concern or responsibility of the MoH alone. There needs to be more inter-ministry collaboration to tackle the major issues if real advancement is to occur.

“And in my view, if the education sector, water sector, infrastructure is developed, the majority of what we are seeing in health definitely would help at the moment... when you look around exactly what are the issues, the issues are around education and

infrastructure. So however much money you pump in reproductive health through the Minister of Health you unlikely to see anything significantly improvement unless you address the issue of roads like these people are, unless you address the issue of education so that they are aware of the dangers in the signs of pregnancy.”

- Representative from the Kenyan Ministry of Health

Operational Environment

The business environment significantly affects the ease to which the social enterprises can set up and operate. Although the process is improving as the government focusses on increasing efficiency, getting the necessary licenses is often difficult, costly and slow. Working in low-income areas also tends to raise the security concerns, which presents further obstacles. Many clinics struggle with security issues including violence and theft, especially in their initial years of operation before the communities accepts them. On the issue of security, one of the SE respondents discussed the challenge they had in their early years:

“We were scared about shadows, because we were working in a very insecure area and those guys are having a field day with us, threatening us and all of that before we settled.”

Many SEs also noted accessing and developing appropriate management skills as a substantial challenge. This includes dealing with issues such as working capital gap management and payment delays. Despite these challenges, data suggests that stakeholders do note Kenya as a supportive context for doing business. As the UNDP noted, Kenya has fallen in its ratings as a supportive business environment recently. Nonetheless, this in turn has warranted the increased attention of involved bodies to prioritize the productive engagement of the private sector (Griffin-El et al, 2014).

Support Organisations

The support environment within Nairobi is substantial. It serves as the regional hub of innovation. Many international and regional organisations have their head offices in Nairobi and as such, the landscape is full of opportunities. While there are a lot of resources available within Kenya (and especially Nairobi) there is limited awareness of the different options. This leads to an underutilisation of available options. One of the support organisations specifically

addressing this is the Aspen Network of Development Entrepreneurship (ANDE). They are in the process of creating a database that draws together all information regarding available resources and opportunities for different kinds of support and presents them in a single location. Available resources on offer from the different support organisations include funding, skills development, promotion and networking.

Universities are also starting to play a bigger role with more of them offering programmes in social entrepreneurship and innovation. This supports the findings of Brower (2011) that universities in developing countries are increasingly teaching entrepreneurial skills and providing training in sustainable development. There is also a lot opportunities arising for incubation and skills training for entrepreneurs. Many of the support organisations recognise the gaps within the SE ecosystem and are actively working towards filling them. While collaboration between SEs is limited, as the support environment expands and gets more connected to the SEs in the space, this is likely to improve.

4.1.7 Establishing the Model and Realising the Mission

Whilst all the barriers, enablers and environmental influencers are being taken into account and navigated, the model continues to get established. During this process, there are regular assessments, adaption and improvements being made. A prominent theme that came up with all the SEs interviewed was the evolution of their models. This evolution occurs to better meet their own (often growing and changing) business needs, to better fulfil their mission and to better meet their beneficiaries' needs. This aligns with Smith, Gonin and Besharov's (2013) study on SEs managing social-business tensions, where they note the dual goals of developing financial sustainability as well as social impact. As the SEs' understanding of the situation evolves, so too does the mission and the strategy for best fulfilling it.

It is the context that shapes the evolution and growth of the SE. Other scholars have reviewed the role of context on innovation and have also found it to be an important factor (Rogers, 1995; Poole, Van de Ven, Dooley & Holmes, 2003; Dopson, Fitzgerald & Ferlie, 2008). Dopson, Fitzgerald and Ferlie (2008) in particular go on to study the role of context in change processes within healthcare settings in greater depth. They find that not only does context shape the direction and design of the SE, it also affects how well it is received. The primary features of contextual receptivity that were found include a mix of indicators of structure and process. Structural features included the degree of system complexity and level

of volume of clinical work; more processional indicators included the historical development of services and a foundation of good prior relationships. Some important features of action include credible opinion leaders; presence of change management and project management skills as well as support from senior management (Dopson et al, 2008: 228).

An important element of the evolution process is making informed choices and using statistics to improve care. A number of SEs conducted research into what would be most effective to reach their target market or tracked usage data at their sites so they had the relevant information to make better decisions. Many also mentioned how much is learnt by doing. The process of trial and error, keeping an ear to the ground and making continuous improvements as the SE moves forward is an integral part of the SE's life cycle. Two SEs are captured below discussing the importance of informed process design and decision making:

“If you ask a good number what’s your outreach cost of an admission, how long do your patients on average stay in hospital? What’s your mortality rate or referral rate or the, you know any of those things, they can’t tell you because there is no system tracking. They only know what they are doing with the patient in front of them.”

“Conducting research with women and girls to understand what information they seek, what they like, what other experts have proven to be effective, and what methods, and do some media information happen to be effective ...and we are distilling them into twelve comments to start which will be bundled into our pad packages and distributed alongside them to women and girls.”

Over time the mission would also expand. This could happen because of increased capabilities being put to use, or a deeper understanding of the needs on the ground being incorporated into the mission. This natural, but still intentional, process of expansion and evolution is important to the establishment of the SE and the realisation of its mission. One of the SEs that were interviewed set up a hospital with the mission to provide quality private hospital care to those who could afford some medical costs, but not at the rates of typical existing private hospitals. Over time, as the model for delivering this affordable, high-quality care was established, an expanded mission emerged:

“For me the greatest value has been that one of my goals in life was to integrate the health care system. The way banks are all linked all over the world... from South Africa, from the UK, somehow the money will find itself to me, but the health care

system, we have a record in this place, another record in that place as a patient, we could probably give you a drug you are allergic to, because your records are in our neighbour's office, or even in our doctor's office within our premises, so one of my life goals is to integrate the system. To basically improve the quality of management of the health care system across the country."

This expanded mission also clearly links into the model too. An integrated healthcare system helps keep costs down, increases efficiency within the hospital and allows for the extraction of reliable data for decision making. The mission and the model continue to impact each other and drive innovation further.

4.2 Other Emerging Themes

A number of other themes emerged during the analysis that do not directly tie into the theoretical framework presented above but speak to the ecosystem for SEs in Kenya. These will be addressed here. They include 1) challenges relating to the definition and application of the term 'social enterprise'; 2) contextual findings surround the ecosystem of SEs in Kenya; 3) the dynamics donor culture and influence of the 'West'; and 4) the difficulties and importance of measuring the impact SEs have.

4.2.1 Challenges identifying to the term 'social enterprise'

Within the Kenyan context, stakeholders generally agreed with or understood social enterprise as a business operation with social and environmental objectives at its core. Cross-subsidization models were frequently part of SEs revenue models, as well as fee-for-service models that catered to the patterns of earning, spending, and decision-making that takes place in the BOP market (Griffin-El et al, 2014). Models and understanding of SEs varied substantially. Some SEs self-identifying with the term whilst others, although they could be characterised as an SE, tended to avoid labelling themselves as such. There was a distinct lack of a uniform and generally accepted definition of social entrepreneurship and the 'social enterprise'. When asked whether they viewed themselves as social enterprises, two different SEs responded:

"Well we have never quite defined ourself as one. All we know is that when we were starting off, we had a very clear vision. We wanted to fill the gap between the leading private hospitals that were very expensive, high quality, high expense and the public

health care system. We thought there was a gap there for people who could afford something private, but certainly couldn't afford five star, if we call it that."

"The way I look at a social enterprise, it is 1) an organization that has a contribution to make to the society that one is positive. 2) it is reaching the masses and helping the masses without having the masses to pay for some of the services you are giving out with the aim of – in our case we are giving it out at the aim of securing life"

It also emerged that many stakeholders were not aware of the term social enterprise. A few SEs also did not refer to themselves as SEs. Moreover, the public sector and even some enterprise support organisations are not entirely aware of the SE space or the organisations involved in this space. On several occasions, researchers were asked to explain or define social enterprise before the interview commenced (Griffin-El et al, 2014). Those who were familiar with the term expressed confusion with the lack of a streamlined definition as it applies to the Kenyan context (ibid). There is also no specific regulation or policy guiding the SE sector.

"From a language perspective we don't consider ourselves to work with SEs, we consider ourselves to work with SMEs [...] and the reason for that is because so many of our SME clients have the highest impact potential you can imagine and would never refer to themselves as SEs. If we come to them and say "You're a social enterprise", they would look at us blankly and say, "No, I am a business", and we like that, we value that'."

– A support organisation respondent

4.2.2 Developing a Kenyan-based SE framework and ecosystem

Although there is not yet widespread familiarity with the term social enterprise, stakeholders across the board resonated with the concept once it had been articulated. They also identified how their organisation or enterprise fitted within the conceptual framework proposed by the study (Griffin-El et al, 2014). It was felt that there is an opportunity to develop an understanding of SE that reflects the perspectives of Kenya's social reality and innovative potential. This would tie in well with the goals outlined in Kenya's Vision 2030 and would develop a coherent national dialogue around social enterprise and its role in Kenya according to the country's vision (ibid).

Stakeholders mentioned the absence of a united front or representation of the social entrepreneurial community by which interested stakeholders could harmonize their efforts and the interests of the social entrepreneurial arena. Several actors mentioned the necessity to work closely with government to help shape the social entrepreneurial agenda, as well as the need to establish trust on the ground, between organizations and institutions and community members. One of the interviewed government agencies suggested that, after finalising the framework and receiving endorsement from stakeholders across the board, the concept should be popularised in a short, accessible report. This was envisioned to be the beginning of a nation-wide campaign to familiarize the public to social enterprise as articulated by the Kenyan context (Griffin-El et al, 2014). One SE expressed a desire for the GoK to be doing more to encourage innovation and practically support those with viable ideas that improve social wellbeing.

*“I think there should be a department, either a department or an agency, or something. Somewhere where somebody with an idea that is extremely viable can go and present it and you know, get support in terms of a business plan, development or just resources... Right now the only way to do that is to go and attend all these business plan competitions... Otherwise there is nowhere, **I’m sure there are many people with brilliant ideas, but where do they go?**”*

Consensus on a definition for SEs and a developed framework for understanding and support would also help to address the issues surrounding the legal status and tax structures for SEs. There were mixed views about whether a specific legal status for SEs would be beneficial. Some noted that the legal structure in place in Kenya are already established and effective and that a separate legal entity for SEs was unnecessary. They also proposed that the flexibility allowed by the absence of a special legal entity enabled each SE to take on the legal status that would best serve its mission and model. Those arguing in favour of a special legal entity stated that acknowledgement of social enterprise as a separate entity would lead government agencies to develop regulation customized to meet the sectors’ needs and challenges (Griffin-El et al, 2014). This would help formalise appropriate tax structures and lend clarity as to who is in the SE sector and who is not. A difficulty with this, as other authors (prominently Schramm, 2010) have argued, is that all entrepreneurship is inherently social. They note that “in the course of doing business as usual, these regular entrepreneurs create thousands of jobs, improve the quality of goods and services available to consumers, and ultimately raise standards of living” (Schramm, 2010: 21). This makes it difficult to include or exclude entrepreneurs on the basis of social impact.

Although some felt that having a rigorous definition and inclusion policy would undermine the inclusion nature of the sector, other argued that it would legitimise the sector and attract more specific funding and support. One SE respondent expressed his opinion, advocating for the existing legal structures to stay but promoting the idea of tax considerations for those with a social mission:

“I’m not sure getting us a different set of legal those that cater for that is actually the way to go because already the legal structure is very, very solid. Perhaps the physical policies is all they need to look at and what I mean by this is local taxation structure if a company is involved in social enterprise work then the taxation to that company should be looked at differently just like the taxation for NGOs is different and then the taxation for corporate limited consultants. That would be a big plus because then it would encourage every company to do something that is socially inclusive and benefit the society at large and at the same time do their business...it’s a win-win for everyone.”

4.2.3 Dynamics of Donor Culture and the Influence of the ‘West’

A tension that exists within the SE space is how to navigate the dynamics of donor culture. A few SEs commented that they wanted to step away from the donor world completely as the accompanying challenges were not always worth the benefits. For example, donor funding is often unpredictable, a lot of time has to be diverted to donor relations rather than being spent on the SE itself, there were often strings attached and the donor can place pressure on the SE for certain issues to be prioritised that may not be in direct line with the SE’s mission. There were also dangers with mission creep, where more and more agendas got added to the initial vision that did not stem from an understanding of the real needs on the ground but rather from the donors’ own plans. Many SEs felt it was important to have a clear vision and a sustainable model that matches the vision without sending mixed messages. One expressed it as follows:

“You acquire a certain language when you’re in the non-profit world in terms of how you engage with everybody. In the business side we call it impact, you know, investing for impact, I was there, there’s always some need that has to be addressed through this kind of support and I felt we were not going to build a robust organisation that would be alive and kicking and growing 100 years from now if we kept focusing on it as a non-profit and I felt people can afford what we are doing out there, we are running

small businesses, you know, it's just that the organisation that was supporting the small business was non-profit, were also kind of sending mixed signals."

Another challenge is where to draw the line between catering to the expectations of western audiences rather than to the needs and culture of the local community. Some Kenyan run SEs struggle to get finance and recognition without the exposure to western audiences, especially as many of the support systems and grant programmes are international.

"I think there is a lot of pressure to appeal to western audiences with your business, meanwhile our business issue needs to be focused on the attending market, and I think that western audiences expect a certain look and feel from social enterprises. [I know of] about ten other companies that are run by Kenyans and I feel like they don't have because they not – I mean they don't have that exposure as easily to western audiences as we do because we have Americans on our team but their companies are amazing and really doing great things and they're just doing it because there is a market need for it. ...but you're going to have to worry about marketing your company to your customers and then marketing your company to your donors in various regions."

- SE respondent

4.2.4 Measuring Impact

Enterprises and support institutions have noted that knowing how to report impact takes a lot of time, energy, financial resources and special expertise. Such costs serve as a disincentive to organizations to properly evaluate the outcomes, degree of systemic change, and the positive and negative externalities that result from their work. The systematic measurement of impact, while difficult, is important. Incorporating impact criteria into the initial conceptualization of the business model from the onset can help mitigate measurement difficulties down the line. This however is difficult to do, especially in the face of all the other challenges taking up SEs time in the early phases. Ebrahim and Rangan (2014) address the issues surrounding the importance and challenges of measuring impact for social entrepreneurs. They offer a framework for determining which kinds of measures are appropriate, as driven by the mission and goals of the organization. They argue that it is not feasible, or even desirable, for all SEs to develop metrics at all levels of a results chain, from immediate outputs to long- term societal impacts. The more important challenge is one of alignment: designing metrics and

measurement systems to support the achievement of well-defined mission objectives (Ebrahim & Rangan, 2014: 119).

Another emerging theme related to the measurement of impact is how the SEs define success. While the majority of traditional enterprises view success in terms of monetary gain, for the SEs interviewed, money is a means rather than an end in itself. Smith et al (2013) further explore this tension of defining success across potentially conflicting goals of business results and social impact. They discuss how different metrics for measuring success can lead to dominance of either business goals or social mission. This study however, found that while sustainability is important, the real successes for the social enterprise are the realisation of their mission and the human impact they achieve. Katzenstein and Chrispin (2011), in their study on social entrepreneurship in Tanzania and Cameroon, argue that while the business process is important (and as such there is a goal to improve the quality of the processes), the process becomes secondary in the sense that the quality of the process makes the system more or less efficient, but the goal of the system is still results. Two different SEs expressed this in the interviews:

“Nigeria 2011, in August, 64 children died because they took rat poison that was [marketed as] those anti-malarials... we have given parents a chance to identify the genuine anti-malaria products so we actually saving kids’ lives as well.”

- SE respondent addressing the counterfeit drug market

“Yeah, every day I want to see numbers coming in, so that ability to reach out to more and more people, because we’re here to provide health care and that’s what, that’s how we have felt our success.”

- SE addressing lack of affordable, high-quality healthcare in low-income areas

4.3 Summary of Propositions and Core Theme

The following are the set of emerging propositions that summarise the findings from the grounded theory process.

- To the social entrepreneur, an identified need or gap in the provision of healthcare is also an opportunity for improvement.
- The primary needs in Kenya's health sector are 1) improving the quality, accessibility and affordability of healthcare and 2) innovating products and models to achieve this.
- The character, perspective and experience of the social entrepreneur(s) in combination with the identified needs (opportunities) drives innovation in Kenya's health sector.
- These two drivers continue to influence and frame the entire SE process.
- After the concept for the SE has been formulated, the mission and model revolve around this concept, influencing each other in turn, until a solution is created.
 - The creation of the model is a process that is intrinsically linked to the mission and is fuelled by an understanding of the reality facing the SEs beneficiaries.
 - Community engagement, past experience and knowledge gained from 'on the ground' understanding shape the model.
 - Because of the imperative to maintain low margins and offer low costs to consumers whilst still remaining financially viable, a great emphasis is placed on efficiency.
- Challenges facing the SE can represent opportunities for innovation and growth or can act as significant obstacles in the life cycle of a social enterprise.
 - SEs in the health sector struggle to find, attract and retain adequately qualified professionals.
 - Accessing finances is difficult for a new SE.
 - Traditional existing credit is expensive, highly adverse to risk and inflexible.
 - There is limited awareness of the non-traditional opportunities that exist.
 - SEs experience breakthrough with financing when someone from the financial community believes in their mission and is willing to take a chance on them.

- Many new ventures, especially those that challenge the status-quo, face initial scepticism from the communities they work in as well as from their mainstream contemporaries.
- Although initial acceptance is a barrier, if it is overcome, it turns into an important enabler and allows the SEs' work to have greater impact.
- Enablers are the factors that create a conducive environment in which social enterprises can develop and operate and allow them to overcome the challenges encountered.
 - Social capital, partnerships (both within and outside the industry), community engagement and the use of technology are important enablers for SEs in the health sector in Kenya.
- Environmental influences can positively or negatively shape the ability of the SE to operate and affects the extent of its impact.
 - Key influencers are the infrastructural, political, operational and support organisation environments.
- The model and the mission continue to evolve and expand to better fulfil its mission, more effectively meet its business needs and respond the feedback it receives whilst operating.
- The SE ecosystem in Kenya is currently ill-defined and could benefit from a context specific framework to support and develop the space.

All of these propositions and theory are grounded in the existing context and have been discovered after extensive analysis of the data collected. The core theory that has emerged from the research is how ***a social enterprise that has impact in a developing country's health sector is established and affected***. All other themes and categories relate to and inform this central concern. It is expected that time and further research will either confirm or challenge these propositions and evolve the theory. Both are welcomed.

5. RESEARCH CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE STUDY

5.1 Introduction

The study set out to explore the concept of social entrepreneurship as it applies to the health sector in Kenya. It sought to identify the barriers and opportunities in the surrounding ecosystem and generate a theoretical framework that answers the primary research question: *What drives and affects innovation among social enterprises in Kenya's health sector?* This is important as it has the potential to inform action on how the challenges facing social enterprises can be minimised, the existing structures of support enhanced and innovation encouraged. It also expands the field of knowledge on an area that has direct development implications. At present, there is very limited research available on social entrepreneurship in a developing country setting and even less on its application within the health sector (Smith et al, 2013). As an exploratory study, an open, grounded qualitative approach was adopted to allow the generation of insight into this little understood context. The following additional research questions helped frame the study:

1. Who are the key actors and how do they shape the environment for social entrepreneurship within the health sector in Kenya?
2. What are the key challenges and barriers to innovation through social entrepreneurship in the health sector in Kenya and how have social enterprises dealt with these?
3. What are the key needs and opportunities that spur innovation within the health sector in Kenya and what are the models that have been created to meet these needs and exploit these opportunities?

5.2 Empirical Findings

The themes that emerged from the data throughout the study support the following primary conclusions: 1) *The character, perspective and experience of the social entrepreneur(s) in combination with the identified needs (opportunities) drive innovation in Kenya's health sector* and 2) *Challenges, enablers and environmental influencers (infrastructure, regulatory/political, support and operational) affect the operation and innovation of social enterprises in Kenya's health sector.*

The key challenges that emerged were access to talent, access to finance and overcoming public scepticism to gain acceptance from both the customers/beneficiaries and

other professionals in the field. Once these challenges were overcome by the SE, they became supportive features. Key factors that enabled the SEs in this study to overcome the barriers they faced and allowed them to continue innovating and growing effectively were the use of social capital, partnerships, community engagement and technology.

Addressing the secondary research questions, the key actors for social entrepreneurship within the health sector in Kenya are 1) the social entrepreneurs and their team that form the SE; 2) the government departments that design and implement policy affecting the business environment and health sector; 3) the support organisations that offer advice, funding and other services to SEs in the region; 4) actors in the operational environment, such as finance institutions, development partners, donors and businesses in the supply chain of the SE; and 5) the beneficiaries and communities that the SEs operate in. Each have a role to play in shaping the environment for SEs. Of these, one of the most influential players (aside from the social entrepreneur) is the government. They have the ability to create a framework that supports and encourages SEs, rewards innovation and provides opportunities for funding and skills development appropriate to the SE. They also play a significant role in building a conducive environment for business, which makes the SEs operations smoother and more cost effective. This could include minimising the cost and time for getting licenses, improving infrastructure so that transport networks, ICT services and physical utilities are effective and accessible and offering clear processes for legal and tax tasks.

A prominent emerging theme was how the needs within the health sector spur innovation and offer opportunities for SEs to develop models that meet those needs. The primary needs in Kenya's health sector are 1) improving the quality, accessibility and affordability of healthcare and 2) innovating products and models to achieve this. Most SEs focussed on initiatives that 1) improve access and delivery models; 2) increase quality of care in existing delivery systems; 3) find ways to reduce the cost of care through innovative saving models and insurance plans to reduce out of pocket expenses by risk-pooling; 4) improve supply chain mechanisms to ensure access to quality medicines; 5) create efficient scale up of operations and 6) find ways to bring better care to poorer areas to decrease the substantial inequality in care that currently exists in the Kenyan health system.

5.3 Theoretical Implications

This study has served to broaden and deepen the understanding of the role social enterprises play in a developing country context. It also expands the literature on the factors that drive and affect innovation. In relation to existing theories, this research corroborates the role, character and influence of the social entrepreneur and how these influences effective innovation in the sector. It agrees with the concept of the social entrepreneur as a change agent who recognises an unmet need in society and adopts a specific mission to create and sustain social value through the use of business-like models rather than primarily pursuing financial value or private gain (Dees, 1998; Thompson et al, 2000; light, 2005; Zahra et al, 2009).

It then goes beyond existing theory to consider the ecosystem within which social entrepreneurship sits in a developing country and sector specific context. Although it has not been established whether the findings of this study hold across other developing countries or different sectors, it provides a grounded theory out of which a deeper understanding arises.

5.4 Policy Implications

Social enterprises in the Kenyan health sector are making significant progress in enriching the lives of the poor and excluded. There is however still more that can be done to enhance a coherent and enabling environment for them. This study has offered suggestions on how the influencing environments can be shaped to have a positive impact on the potential for innovation in Kenya. Specifically, policy and regulation could be better formulated to support and develop SE initiatives. This could include innovation incubation centres, business skills development programmes, special funding opportunities for those enterprises with a specifically social mission backed by the government (where the GoK absorbs some of the risk so that the financial sector is able to provide financing that is not prohibitively expensive or restricted). In terms of support infrastructure, the data suggests that the social enterprise community would benefit from being strengthened so that the exchange of information, knowledge and experience by different stakeholders can be facilitated. This increased collaboration and interaction would help build a sense of trust and support, and unify the sector. On an operational level, continued effort should be directed at developing the business environment so that the required processes can happen efficiently, timeously and cost-effectively.

5.5 Recommendations for Future Research

This was an exploratory study whose purpose was to expand the knowledge and understanding of the field of social entrepreneurship in a country and sector specific context. As such, the priority was on the generation, not testing of theory. A theoretical framework and set of propositions were formed that have been grounded in the data but these have not yet been verified by further qualitative or quantitative studies. This presents opportunities for further research as each element in this study and each proposition could be quantified and tested.

There is also scope for more specific policy strategies to be researched and development targets for the SE sector in Kenya proposed. The study would benefit from a second phase that takes the existing framework and tests it using a larger and more varied sample of SEs in Kenya's health sector. Another interesting perspective to explore would be the influence of the nationality of the entrepreneur or SE team on its ability to attract funding, recognition and resources. This would highlight potential imbalances or gaps in the social entrepreneurship space and offer recommendations to improve it. Although some suggestions were made in this study regarding the development of a Kenyan-based SE framework and ecosystem, a more specific study would be able to do this topic better justice.

The scale of this topic is extensive and multifaceted even at the local level. More case studies, further exploratory research and verification of this study's propositions would facilitate the expansion of understanding in this field. While all of the findings articulated in this study are grounded in the data and true to the context, time and further research are likely to confirm, challenge or extend them.

5.6 Conclusion

Social entrepreneurship is a rising field, gaining momentum and recognition. With the impact it is already having plus its substantial scope for further growth and influence, it is important to understand the dynamics that drive and affect it as well as the ecosystem it sits within. This study has explored the role of SEs in Kenya's health sector and offered new perspectives that are grounded and significant. Whilst the theoretical framework and propositions put forward are embedded in this context, they have relevance for advancing the knowledge in the field beyond this specific milieu.

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Kenyan Healthcare Federation (Health Sector Board for KEPSA): <http://www.khf.co.ke/>

Kenyan Law Reports (NHIF and other Acts):
http://www.kenyalaw.org/kenyalaw/klr_app/frames.php

National Health Insurance Fund website: <http://www.nhif.or.ke/healthinsurance/>

Republic of Kenya Ministry of Health: <http://www.publichealth.go.ke/home>

SocEntLab East Africa: <http://socentlab.blogspot.co.uk/>

Trickle Out Project: <http://trickleout.net/>

WHO Kenyan Country Profile: <http://www.who.int/countries/ken/en/> (*online page with links*)
<http://www.who.int/gho/countries/ken.pdf> (*health profile and statistics*)

APPENDICES

Appendix 1: Summary of Key Stakeholders in the Kenyan Health Sector

Government: Ministry of Health:

- Ministry of Medical Services (Minister Hon. Beth Wambui Mugo, M.P.)
- Ministry of Public Health and Sanitation (Minister Hon. Prof Peter Anyang' Nyong'o, M.P.)
Operate at the district, provincial and national levels.
- After 2013, the two merged to reform a single Ministry of Health (Minister

Medical Practitioners and Dentists Board, chaired by the Director for Medical Services, is responsible for approving private hospitals and clinics and for the overall supervision of the practice of medicine by qualified physicians and dentists in the country.

The National Hospital Insurance Fund is a social insurance scheme established under the Ministry of Health to accommodate and finance the changing healthcare needs of the Kenyan population. Membership of the NHIF is compulsory for formal and voluntary for informal workers, and the scheme covers more than 50% of the cost of curative health care in government facilities.

The Nursing Council of Kenya is a body corporate established under the Nurses Act Cap 257 of the Laws of Kenya to regulate standards of nursing education and practice in Kenya. It protects the public by promoting standards of clinical care through training, licensure and enforcement of codes of regulation.

Kenya Medical Supplies Agency is a specialised medical logistics provider for Ministries of Medical Services/Public Health-supported health facilities and programmes.

Kenya Healthcare Federation (KHF) is the Health Sector Board for Kenya Private Sector Alliance (KEPSA). It's mandated to among other things promote and enhance medical care in Kenya with emphasis on the provision of affordable and accessible quality health care to all.

Kenya Medical Practitioners, Pharmacists and Dentists' Union is a workers union aimed at improving the general welfare of all doctors in Kenya and by extension the provision of healthcare to all citizens of Kenya. They have a potential membership of 8000 plus. This includes all doctors whether in the public or private sector, interns, officers, registrars or consultants.

Christian Health Association of Kenya (CHAK): CHAK coordinates the activities of about 230 health facilities in Kenya operated by various protestant denominations. CHAK exists to represent its member-institutions on common issues before the Government of Kenya (GOK), disburse grants from the GOK to member facilities, to coordinate the activities of the facilities on issues of mutual concern and to be the repository of aggregate information on the health activities of member-facilities.

Technology infrastructure/Mobile providers: A lot of innovation in the medical field involves technology and mobile phone use (there is a 74% mobile penetration in Kenya). There are four

mobile network operators, the biggest being **Safaricom**. All mobile network operators are regulated by the **Communication Commission of Kenya**.

- **M-Pesa** (M = mobile and pesa = Swahili for money) is a mobile based money transfer and micro-financing service operated through Safaricom in Kenya. M-Pesa allows users with a national ID card or passport to deposit, withdraw, and transfer money easily with a mobile device. It is currently the most developed mobile payment system in the world and is being increasingly integrated into financing innovation for healthcare.

Healthcare education and training providers: while a number of universities provide training for a range of healthcare professions, it is noteworthy that there is no coordinated and structured legal and institutional framework for the management of health training institutions in Kenya.

Appendix 2: Frameworks of interview questions and protocols for field trip

Social enterprise interview questions template:

Purpose of SE interviews is to gain insight on current operation, characteristics, constraints and opportunities – and their recommendations for overcoming/capitalising on these.

Describe the mission of your organization and the nature of your work.	Basic information: legal status, years in operation, business activities, annual revenues, financial and impact reporting (some of this information may be publically available prior to the interview)
	What are your current products/services? Who are your clients and what are their needs? What is the value chain of your organisation? What are your income generation models?
	What is the mission of your organisation? Why did you start a social business? What are your social business objectives? How do you see your business as different from other normal businesses?
	Are you generating a surplus, and if so how to you use surplus or profit? What is your plan for the next 3 years? If you are seeking to expand, how will you achieve this?
What impact are you having?	What successes are you proud of? What impact have you noticed or been able to quantify? What are the main results in terms of profit and beneficiaries? How do you calculate results?
	What are key milestones in the development of your business? What factors have contributing to achieving these?

What challenges do you face?	What 4 factors most constrain your operations? What influences your sustainability? What influences your ability to deliver social impact or to be innovative? Who are your current competitors? What impact does the policy environment have?
	What are your views on the roles of government and private sector actors who engage in the same space?
	What recommendations do you have for government or donors? Which other stakeholders could be engaged to contribute more?
What types of support have you accessed and how do you engage with peers?	Do you receive support from government? Who are you main service providers and supporters and what are their roles? What further support could you benefit from?
	How do you relate with other SEs? Do you partner with other SEs? Are you part of a sector or SE specific network?
Sector specific obstacles and opportunities	What obstacles and opportunities exist within the market niche your SE operates in? How does your SE interact with other market niches within the sector? What are the pre-conditions to engage in these market niches?

Government/Policy Maker/Regulatory Organisation interview questions template:

Purpose of interviews with government is to understand current policies and initiatives and planned future areas of interest and likely opportunities for engagement.

Background	Description of objectives and working methods
SEs in Kenya	Describe what you know of social enterprises in Kenya and their business model.
	<u>What are your opinions of social enterprises on the following:</u> Their social impact? Their effectiveness? The difference between their business model and other types of enterprises/organizations? Job creation? Economic freedom for the poor?

	<p>What contribution do you think SEs make to development in Kenya?</p> <p>Do you support/encourage to replicate this model?</p> <p>Is there any policy/action to promote: the development of social enterprises and the establishment of other social enterprises?</p> <p>What are the crucial conditions to sustainably replicate/develop this model at local level?</p> <p>What problems are there for SEs in terms of contributing to development?</p> <p>How much focus should they receive? Is the current balance right?</p>
Support to SEs	<p>Please describe any projects/initiatives/campaigns your institution has led concerning social enterprises.</p> <p>In what ways has your organization influenced or supported the SE space in the country?</p> <p>How do you think policies/regulations issued by your institution have affected the SE space?</p>
	<p>In your opinion, what is the role of local departments and agencies in the development of social enterprises during the following periods:</p> <p>Before a social enterprise is established? While social enterprise is operating? In the future?</p>
	<p>What recommendations would you make to social enterprises to improve their effectiveness? To support organizations?</p>
Health Sector	<p>Do you think that the social enterprise business model is relevant to the health sector?</p>
	<p>What do you think are the strengths of social enterprises in carrying forth a mandate of improving access to and the quality of healthcare in Kenya?</p> <p>Their weaknesses compared to other health care providers?</p>

Service provider interview questions template:

Purpose of interviews with service providers is to understand differences in products/services and how these are provided.

Organisation background	Description organisation mission and operations
	How does your organisation interact with SEs? Do you provide services/products? Do you engage with them as part of a wider network of sector actors?
Working with SEs	How did you first start to work with social enterprises? Describe your work with the social enterprise.
	Have you encountered challenges in working with social enterprises? Describe them? In your opinion how could they be addressed?
	Have the needs of the social enterprise(s) you work with changed over time? How has your organization responded to these changes? What are the advantages and disadvantages during this period?
Business model and approach	Of the products/services you offer SEs, how do your products/services differ from others? Consider the following criteria: Features of products/services, price, the way of providing products/services, and cooperation mechanism to support social enterprises
	How would you describe your competition? Availability of local product/service providers? Level of competitiveness?
	How would you describe your market? Availability of similar customers in local and neighbouring areas?
Health Sector	How does regulation of the health sector affect your capacity to work with social enterprises in this sector?
	How does the service or good that you provide contribute to the social enterprise's impact in the health sector?
	What are your greatest accomplishments and challenges in responding to social enterprises' needs in the health sector?

Support organisation interview questions template:

Purpose of interviews with support organisations is to understand the range of support services available, gain perceptions on gaps and challenges, learn about effective/new/innovative approaches, understand needs from government/regulation/other actors.

Organisation overview	What are your organisation objectives? Description of support service your organisation provides: what services and tools? Promoting SEs? Creating support structure? Mobilising private investment? Working with (or as) an intermediary, accelerator/incubator?
	When did you start providing these services? Kenya specific? Social enterprise specific? Sector specific? Do you provide support to any of the SEs we are interviewing? (LIST)
	What projects/programmes have you been involved in recently to promote the development of SEs in Kenya? What lessons have you learnt?
Challenges and opportunities	What are your views on SEs and their impact on development in Kenya? What challenges do you perceive that SEs are facing? What are the opportunities for SEs in Kenya? And SEs in health/agriculture in particular?
	Is your organisation's current approach new, how has it changed recently? Have the needs of SEs changed? How? How have you responded to this?
	What more could you/would you like to do? What stops you? What would help you provide different/additional/better support to SEs?
	What could/should other organisations be doing?
SE ecosystem in Kenya	Who are key individuals and organisations in SE promotion? In the health sector specifically?
	What is the role of government? Of donors? In promoting SEs and helping support organisations to support SEs?
	How does your organisation work with other support organisations? International Organisations: Does your organisation broker relationships between local and global actors involved in SE development? If so, how?
	<i>International Organisations:</i> Compared to other developing countries, how active is Kenya's SE environment?

Looking forward	What future plans does your organisation have?
	<p>What are your opinions on changes needed to remove constraints to SE development? Which actors need to be involved? (government, SE community, support organisations, donors, impact investors, the public?)</p> <p>What recommendations for policy, regulation and communication do you have?</p>
Health Sector	How does your support of social enterprises in the health sector increase the levels of health and wellness in Kenya?
	In your opinion how do health social enterprises engage with actors of the broader health care system in Kenya?
	To which extent do you believe health social enterprises should be integrated into the health care system in Kenya? How do/would you assist them in this regard?

Appendix 3. Overview of Social Enterprises in the Health Sector

(Table overleaf)

Table A1. Overview of Social Enterprises Interviewed in the Health Sector

SE Name	SE Definition	SE model	Start Year	Area of focus (niche)	Sources of finance	Stage of Growth
Access Afya	Seeking long-term partial subsidy from government/ NGO/ donor to sustain business	Micro-clinic - Operate and maintaining essential infrastructure (physical and services) for communities where traditionally it was built and run by public (or intended to by run the state – e.g. universal basic healthcare provision)	2012	Primary care in low-income areas through micro-clinics.	Out of pocket payments from patients and grant funding	Pilot/ validate phase
Alive & Kicking	Purposefully reducing financial surpluses by paying above-market prices to suppliers, above-market wages, and restraining business margins	Product/service subsidisation – uses income from services/goods to fund social activities or cross-subsidise other aspects of the business. Creating sustainable employment in the profitable manufacture of balls and using sport to raise health awareness in sub-Saharan Africa	2004	Health education and awareness through sports, especially focussing on HIV/AIDS.	Business element is self-sufficient and profitable. Health awareness programme grant funded	Breakeven/ sustainable with plans to expand
Melchizedek Hospital	Purposefully reducing financial surpluses by paying above-market prices to suppliers, above-market wages, and restraining business margins	Operate and maintaining essential infrastructure (physical and services) for communities where traditionally it was built and run by public (or intended to by run the state – e.g. universal basic healthcare provision)	2001	Uses cross-subsidisation to provide comprehensive hospital-based healthcare, both in-patient and out-patient, that is affordable and accessible to low and middle income groups.	Revenue, donor funding	Sustainable
Metropolitan Hospital	Purposefully reducing financial surpluses by paying above-market prices to suppliers, above-market wages, and restraining business margins	Operate and maintaining essential infrastructure (physical and services) for communities where traditionally it was built and run by public (or intended to by run the state – e.g. universal basic healthcare provision)	1994	Comprehensive hospital-based healthcare, both in-patient and out-patient, that is affordable and accessible to low and middle income groups. Fully integrated, self-designed software system to increase efficiency and reduce costs.	Revenue	Sustainable

Sproxil	Sustainable for profit business with innovative solution to addressing the problem of counterfeit drugs.	Market intermediary – services to help target population access markets and facilitate trade relationships through the innovative use of mobile technology.	2008	Verification of authentic drugs through mobile technology to combat drug counterfeits in the market.	Revenue	Sustainable and growing
Upper Hill Eye & Laser centre	Purposefully cross-subsidising a specific category of customer as part of core business practice in order to achieve a social objective.	Product/service subsidisation – uses income from services/goods to fund social activities or cross-subsidise other aspects of the business	1998	Provision of specialist eye care to areas where such services would not have been provided.	Revenue	Sustainable
Viva Afya	Purposefully reducing financial surpluses by paying above-market prices to suppliers, above-market wages, and restraining business margins	Micro-clinic - Operate and maintaining essential infrastructure (physical and services) for communities where traditionally it was built and run by public (or intended to be run by the state – e.g. universal basic healthcare provision)	2008	Affordable, accessible primary healthcare via micro-clinics in poor areas made sustainable through the use of a ‘hub and spoke’ model where one larger, more equipped ‘hub’ supports and provides more specialised services to a number of ‘spoke’ clinics	Revenue	Generating surplus, sustainable and scaling
Zana Africa	Seeking long-term partial subsidy from government/NGO/donor to sustain business	Offer needed services to specific groups who are not used to paying for things, at a reduced cost to introduce sustainability, create positive environmental impact, or provide ‘useful’ goods and services for which market demand may be limited, but certain groups benefit	2000	Provision of redesigned sanitary wear to make it more affordable and appropriate for low-income environments. Women’s health awareness and education programmes.	Grant funding and revenue	Outreach programme operational, pads in product development stage

